

# A Medical Sociological Perspective of Doping in Sports

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**Abstract – It is of course not possible to arrive at any precise estimate of the extent of drug use in sport, for those involved in doping will almost inevitably seek to conceal their activities. It is also clear that the incidence of positive tests is a poor - some would argue so poor as to be virtually useless – index of the extent of drug use in elite sport. Although the prevalence of drug use varies considerably from one sport to another it is clear that in many sports doping is widespread and that in some – professional cycling is perhaps the clearest example - the likelihood is that a majority, and perhaps a very large majority, of competitors are using performance-enhancing drugs. Marxist theory which, he argued, would suggest that the practice of doping is indicative of the alienation of individuals in modern capitalist society. Marxist sociologists he suggests, could identify many structural clues that would illustrate 'how the athlete as a controlled human being is exploited and alienated, or how sport itself produces alienation'. The central thrust of this analysis thus focuses on developments in, and changes in the interrelationships between, medicine and sport. Let us begin by looking briefly at the medicalization of sport. It should be emphasized that such a deviant career structure within sports medicine is now firmly established and that it is possible to achieve considerable success within such careers. It would seem that in the case of bodybuilders – and, it might be suspected, in the case of drug-using athletes more generally – the fact that they may form quite tightly knit communities in which drug use is both widely accepted as legitimate and often seen as a prerequisite for success, enables them with some success to reject the hostile stereotyping from the wider society and to sustain their own more positive definition of themselves and their activities.**

**Keywords – Sports, Sociological Perspective, Medical Terms.**

## INTRODUCTION

Sportive nationalism may be defined as the use of elite athletes by governments to demonstrate national fitness and vitality for the purpose of enhancing national prestige. The practice of sportive nationalism can take different forms depending on the nature of the government that seeks prestige benefits from international sporting successes. Unmitigated sportive nationalism of this kind is generally incompatible with the ethos of a democratic society. It is my view that premature condemnations in this area should be avoided, since it would be wrong to measure the quality of a country by the number of its Olympic medals." The doping problem in international sport has complicated the practice of sportive nationalism by requiring that an anti-doping rhetoric accompany the standard rhetoric of competitive success. A similarly entrepreneurial attitude by academics may produce research funding in relation to the third type of policy analysis which is concerned with monitoring and evaluation of existing policy. Monitoring involves the collection of data on which evaluation can be based, but most monitoring in doping is of outputs rather than outcomes.

The central objectives of this paper are: (i) to provide from a sociological perspective, and more particularly from the perspective of medical sociology, an overview of research into doping in sport and (ii) to identify, again from the perspective of medical sociology, problems for further research. Before I address these two key issues, however, it may be useful to outline briefly what is known about current patterns of doping in sport and the way in which those patterns have changed since anti-doping controls were introduced in the 1960s; this is an essential preliminary task, both in terms of identifying the key sociological problems and in terms of developing more effective policy in this area.

## Patterns of Drug Use in Modern Sport

It is of course not possible to arrive at any precise estimate of the extent of drug use in sport, for those involved in doping will almost inevitably seek to conceal their activities. It is also clear that the incidence of positive tests is a poor - some would argue so poor as to be virtually useless – index of the extent of drug use in elite sport (Waddington, 2000). Notwithstanding these difficulties, there is a variety of

sources of information which, taken together, enable us to build up a picture of the patterns of drug use in sport; these sources include autobiographies of leading athletes and ex-athletes, public statements of sports administrators and specialists in sports medicine, and perhaps most revealingly, the evidence of formal judicial inquiries. The data enable us to make a number of points about the level and patterns of drug use in sport with a fair degree of confidence (Waddington, 2000:171-5). Among the more important of these patterns are the following:

1. There has been a substantial increase in the use of performance-enhancing drugs by athletes since anti-doping controls were introduced in the 1960s.
2. In athletics, the use of performance-enhancing drugs, which was originally concentrated in the heavy throwing events, has subsequently spread to many other track and field events.
3. The use of performance-enhancing drugs has also spread from athletics, weightlifting and cycling - the three sports in which drugs appear to have been most frequently used in the 1960s - to most other sports.
4. Although the prevalence of drug use varies considerably from one sport to another it is clear that in many sports doping is widespread and that in some - professional cycling is perhaps the clearest example - the likelihood is that a majority, and perhaps a very large majority, of competitors are using performance-enhancing drugs.
5. The use of performance-enhancing drugs has undergone a process of diffusion from elite level sport to lower levels, with anabolic steroids being freely available and widely used in many gyms, particularly those frequented by bodybuilders.

These data provide an important starting point for any analysis of drug use in sport for two reasons. Firstly, it is important to recognise the very limited effectiveness of current policy; indeed, the most charitable judgement which can be made of that policy is that 'it isn't working well' (Waddington, 2000: 176). This is in fact Goode's conclusion in relation to anti-drugs policies more generally in Indian society, and his words would seem to be equally appropriate as a judgement on anti-doping policy in sport. The data on drug use also point up the key sociological problem which requires answering before we can properly address policy issues: how do we account for the increase in the use of performance-enhancing drugs since the 1960s? This brings us to a consideration of the major sociological approaches to drug use in sport.

### Sociological approaches to drug use in sport

In a useful review of work on doping in sport, Lueschen (1993) identified several theoretical approaches to understanding the use of performance-enhancing drugs in sport. Amongst these he listed the following:

- A) *Marxist* theory which, he argued, would suggest that the practice of doping is indicative of the alienation of individuals in modern capitalist society. Marxist sociologists he suggests, could identify many structural clues that would illustrate 'how the athlete as a controlled human being is exploited and alienated, or how sport itself produces alienation' (1993: 100).
- B) Lueschen recommended Merton's work on social structure and anomie as a theory that has 'explanatory potential' in relation to drug use in sport. In his classic analysis, *Merton (1957)* identified several types of what he called 'individual adaptation' to patterns of cultural goals and institutional norms. Merton's typology of behaviour was based on the identification of culturally prescribed goals and institutionalised (legitimate) means to achieve those goals.
- C) The theory of differential association developed by *Sutherland and Cressy (1974)* is seen as useful in that it suggests that the use of performance-enhancing drugs cannot be understood as the behaviour of an isolated individual, for the use of drugs implies not only a network of relationships between users and suppliers, but drug use itself is seen as a process involving learning from, and encouragement by, others.

The so-called 'pharmacological revolution' is clearly a process which has to be taken into account in any attempt to explain the increase in drug use; however, in more or less ignoring other social processes associated with changes in the structure of sport and sporting competition, the argument of Coakley and Hughes becomes, in effect, a form of technological determinism, with all the weaknesses associated with such theories.

Three general points can be made about the approaches outlined above. The first is that the sub-discipline within sociology from which most of these frameworks are drawn is not medical sociology, but the sociology of deviance; indeed, the subtitle of Lueschen's review - *the social structure of a deviant subculture* - is revealing in this regard. The second point is that some of the above frameworks offer descriptive labels which may be considered more or less useful, but do not provide what might properly be described as *explanations*. This is particularly

relevant to Merton's work and to aspects of the work of Coakley and Hughes. The characterisation of drug use in sport as either 'innovation' or as 'positive deviance' may provide us with what may be considered useful descriptive labels but such labels do not significantly help us to understand *why* athletes engage in the behaviour which is so labelled.

The third – and very important – point is that, with the exception of the technological determinist explanation of Coakley and Hughes, all of the above approaches are couched in static terms; in other words they seek to answer the question: why do athletes take drugs? However, the more revealing and sociologically more useful question is: why have athletes over the past four decades *increasingly* used drugs? This question cannot adequately be answered without adopting a different approach which centres on the changing relationship between sport and medicine. It is here that the perspective of medical sociology has much to offer.

### **Medical Sociological Approaches**

In the early 1990s, several authors began to draw attention to the importance of understanding the increasingly close relationship between medicine and sport as a basis for understanding drug use in sport. A key text in this regard was Hoberman's *Mortal Engines*, published in 1992. Hoberman argued that in the early years of this century, 'sport served the ends of science rather than the other way round', for sport was seen as just another form of human activity the study of which could aid our understanding of human physiology. In contrast to that earlier period however, 'the modern outlook sees symbolic importance in the pursuit of the record performance, thereby putting physiology in the service of sport'. This was a critically important insight.

The central objects of this work were to try to account for the increase in the use of performance-enhancing drugs since the 1960s and to analyse the role of sports physicians in that process. The central thrust of this analysis thus focuses on developments in, and changes in the interrelationships between, medicine and sport. Let us begin by looking briefly at the medicalization of sport.

### **The Medicalization of Sport**

The medicalization process in society generally has involved growing dependence on professionally provided care and on drugs, the medicalization of prevention and the medicalization of the expectations of lay people regarding health-related issues (Zola, 1972; Illich, 1975). In recent years, the medicalization process has encompassed sport. Central to this process has been the development, particularly since the 1960s, of sports medicine, which is premised on the idea that highly trained athletes have special

medical needs and therefore require special medical supervision.

Two points about the development of sports medicine are of particular significance. Firstly, as *Houlihan (1999:88)* has noted, the development of sports medicine has been associated with the development of a culture which encourages the treatment not just of injured athletes, but also of healthy athletes, with drugs. Secondly – and of particular significance for the present argument – the relationship between athletes and sports medicine practitioners goes beyond the treatment of sports injuries for, as the British Medical Association's (1996:4) definition of sports medicine indicates, sports medicine is concerned not just with the 'prevention, diagnosis, and treatment of exercise related illnesses and injuries' but also with the 'maximization of performance'. One consequence of this growing concern of sports physicians with the maximization of performance has been to make top-class athletes more and more dependent on increasingly sophisticated systems of medical support in their efforts to run faster, to jump further or higher or to compete more effectively in their chosen sport; indeed, at the highest levels, the quality of medical support may make the difference between success and failure.

### **The Increasing Competitiveness of Sport**

Athletes are not, however, simply unwilling 'victims' of medical imperialism. Several developments in the structure of sporting competition, particularly in the post-Second World War period, have led sportsmen and -women increasingly to turn for help to anyone who can hold out the promise of improving their level of performance. The most important of these developments are probably those which have been associated with the politicization of sport, particularly at the international level, and those which have been associated with massive increases in the rewards – particularly the material rewards – associated with sporting success. Both processes have had the consequence of increasing the competitiveness of sport, one aspect of which has involved the downgrading, in relative terms, of the traditional value associated with taking part whilst greatly increasing the value attached to winning. This is an important part of the context for understanding the increasing cooperation between athletes and sports physicians in the search for medal winning and record-breaking performances; it is also an important part of the context for understanding the increasing use of drugs in sport.

### **The Sport-Medicine Axis**

Sports medicine is a legitimate area of specialist practice. There is, however, a substantial and well documented history of the involvement of sports physicians in the development and use of

performance-enhancing drugs; note, for example, the central role of Dr John Ziegler, the US team doctor at the 1956 World Games in Moscow, in the development and dissemination among the weightlifting community of the first widely used anabolic steroids; the systematic involvement of doctors in doping in the former East Germany; and the involvement of sports medicine specialists in the development of blood doping (Waddington, 1996).

As long ago as 1988, a leading UK medical journal, *The Lancet*, published an article under the title *Sports medicine - is there lack of control?* It suggested that although 'evidence of direct involvement of medical practitioners in the procurement and administration of hormones is lacking, their connivance with those who do so is obvious and their participation in blood doping is a matter of record'. It concluded:

If the Dubin Commission marked one watershed in the history of the use of performance-enhancing drugs, then the scandal in the 1998 Tour de France may come to be regarded as a second watershed, particularly in terms of the amount of information that was made available about the systematic and organised use of performance-enhancing drugs in professional cycling and about the pivotal role of team doctors in this process (Waddington, 2000:153-169). Perhaps not surprisingly, almost all the media coverage of the doping scandal in that Tour was heavily emotive and did little to enhance our understanding of the processes involved. It is a complex regime, with maybe 20 different components. Only the team doctor has this exhaustive knowledge, and thus the average professional cyclist with no scientific background becomes not a partner but a patient. He opens his mouth, holds out his arm, and trusts. That trust, not the reflex shriek of 'drugs, the excrement of Satan', should be the crucial point in the whole discussion (*Times*, 25 July, 1998). This point was clearly brought out by Cramer in his report on the use of blood doping by the United States cycling team at the 1984 Olympics. After the Olympics it was revealed that most of the American team, which had dominated the cycling events, had been blood doped and, shortly afterwards, the technique was banned by the International Olympic Committee (IOC). Cramer (1985:25) wrote:

In the national euphoria after the games, no one thought to pry out any secrets. The US team had won nine medals, dominating the cycling events. 'Great riders....' 'Great coach....' 'Great bikes....' said the press, reporting the daisy chain of back pats. No one thought to add, 'Great doctors ...'.

### Physician Behaviour and Deviant Medical Careers

We know a good deal about the constraints faced by elite level sportspeople and the ways in which these constraints – particularly the greatly increased

importance which has come to be attached to winning - lead many athletes to accept and internalize values associated with a 'culture of risk'. This involves a generally high level of tolerance of pain and injury and a willingness to 'play hurt', ie to continue training and competing with pain and injury and, in many cases, to accept the risks associated with the use of drugs, both licit and illicit. What has been much less studied are the constraints on team physicians to deviate from conventionally accepted standards of professional behaviour. In much the same way that it is important not to see the drug-using athlete as an isolated individual, so it is equally important not to see drug-prescribing doctors as isolated individuals, but to examine the everyday constraints on their behaviour and the ways in which these constraints might open up deviant careers within medicine. It should be emphasized that such a deviant career structure within sports medicine is now firmly established and that it is possible to achieve considerable success within such careers. Dr Jamie Astaphan, developed considerable expertise in relation to steroid use and that he was consulted by leading athletes from all over the world. It is also clear that this can be a substantial source of income for practitioners who build up large practices among athletes. The issue of deviant medical careers also raises a number of other sociological issues, including those relating to colleague control and professional self-regulation and, of course, socio-legal processes relating to malpractice issues.

### Doctor-Patient Relationships

While the basic structure of the relationship between doctor and patient is defined by the fact that the former is an expert and the latter is a lay person, the relationship is also significantly shaped by other processes associated with the relative power and status of the two parties. In the literature on doctor/patient relationships, most emphasis has been placed on the social class and gender dimensions of these relationships; however, there may be special status-related considerations relating to relationships between physicians and athletes.

How, for example, is the relationship between doctor and athlete affected by the fact that, while the doctor may occupy a relatively modest place within the medical profession – sports medicine is, after all, hardly the most long established or most prestigious specialism within medicine - his/her 'patients' may be wealthy and world famous athletes? Many sports physicians have a deep personal interest in sport and they may well identify with the work and success of their athlete 'patients' to a much greater degree than is the case with their ordinary patients.

### Lay Referral Systems

A referral system is a network of relationships within which people consult and obtain information about



health-related issues (Freidson, 1960; 1970). In relation to drug use in sport, a central question is: whom do athletes consult, and where and what kind of information do they get, about the use of performance-enhancing drugs? At the elite level, such referral systems may be relatively closed. At this level, the differences between lay and professional referral systems – that is, the differences between professional and lay understandings of drug use – may be relatively small, for the athletes will often be working with physicians who will be their major source of advice.

However, at non-elite levels, physicians appear to be relatively insignificant as sources of advice; a major study of anabolic steroid users in Indian gyms found that the major sources of advice are friends (35.8%), anabolic steroid handbooks (25.7%) and dealers (20.2%). There are undoubtedly health risks associated with this pattern of obtaining information; the steroid users would sometimes recommend doping practices different from those they used themselves while some men may provide advice to women based on their - the men's - own experiences, which could have serious consequences for female anabolic steroid users in terms of virilising effects. This study also found that 'the majority of Anabolic Steroid users would welcome medical involvement but are unable to get the supervision they would like'. Such data raise important questions about whether we should be moving away from traditional punitive approaches to drug use and towards harm reduction policies involving the provision of specialist medical advice on a confidential and non-judgemental basis.

### **Athletes' Definitions of Their Drug Use**

Those outside the community of drug-using athletes generally hold strongly negative stereotypical images, perhaps fuelled by emotive media coverage, of those who use drugs. But how do athletes themselves perceive and justify their use of drugs? The situation will almost certainly vary from one sport to another, but where those involved in the use of drugs constitute a relatively cohesive community, they may develop a relatively clearly articulated rationale in relation to their use of drugs.

A pertinent study in this regard is Monaghan's recent (2001) work on bodybuilders. The popular negative stereotyping of bodybuilders as 'steroid freaks' subject to 'roid rage' is clearly brought in Monaghan's book, but what is of particular interest are the bodybuilders' responses to, and their rejection of, these negative stereotypes. There is, he suggests, 'a general perception among bodybuilders that they inhabit a community under threat, leading many to engage in discursive stratagems to resist connotations of moral or social odium'. One such stratagem involves pointing to the deficiencies of 'bodybuilder' and 'bodybuilding' as descriptive labels, while stressing that their pursuit should be conceived

as a process of shaping, refining and sculpting the body rather than simply building size. It would seem that in the case of bodybuilders – and, it might be suspected, in the case of drug-using athletes more generally – the fact that they may form quite tightly knit communities in which drug use is both widely accepted as legitimate and often seen as a prerequisite for success, enables them with some success to reject the hostile stereotyping from the wider society and to sustain their own more positive definition of themselves and their activities. Such issues would repay further study.

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