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Conclusion

In 2009 the city of Leicester hosted the Special Olympics Great Britain (SOGB) National Summer Games. The Special Olympics movement had been founded in America in the 1960s and catered for athletes with learning disabilities. SOGB was formed in 1978. It was part of the British voluntary tradition, which relied on the efforts of its members to run competitions and training programmes for athletes. SOGB embraced a Sport for All philosophy rather than one geared up for elite competition. Events within the games were classified not according to disability as in the Paralympics but on an athlete's ability. SOGB has around 8,500 athletes while in 2008 an estimated 2.25 million athletes worldwide took part in Special Olympics sporting activities. In a number of ways Special Olympics echoes some of the ideas around health that have been associated with sport since the Victorian era. Special Olympics have been hugely beneficial to the lives of the athletes and families involved.¹ The Games themselves carry important wellbeing and health rewards – people with learning disabilities have been amongst the most poverty stricken and least healthy in society – as well as a sense of a positive, collective shared experience during the week. For athletes, training for and then competing at the Games improves fitness levels and wellbeing, and gives them a sense of purpose and confidence: *mens sana in corpore sano*.

The Paralympics have provided a different lens through which to view the development of the relationship between sport and medicine. These had emerged out of the Stoke Mandeville Games, founded in 1948, as part of the rehabilitation – both physical and mental – of injured servicemen from the Second World War.² By the mid-1960s the status and meaning of disability had begun to shift with the emergence of identity politics and the demand for greater leisure provision as part of a move to greater social inclusion. Although initially built on the basis of health, disability sport took on a life of its own and became a fixture in the global sporting calendar. In 1988 Seoul hosted the first official Paralympics. In more recent years, especially in Britain, Paralympians have also benefitted from significant state investment and through television coverage have been able to develop their own personalities and celebrity culture similar to able-bodied athletes. Unlike the Special Olympics, the Paralympics are highly competitive and have not been without cheating scandals. For example, some of the Spanish basketball team that won the learning disability category at the 2000 Sydney Paralympics did not have learning disabilities. The Paralympics have also been wrought with issues over the identity of disabled athletes because it has reinforced as well as challenged notions of disability. In particular, the medical categorization of athletes, based

on functional difference, has given disability an (unwanted) cultural legitimacy and a sense of stigma because it creates a hierarchy amongst Paralympians.³

Further ethical debates not only over the identity of Paralympians but also of able-bodied athletes were raised at the 2011 World Athletics Championship. Oscar Pistorious, the South African 400 metre runner, became the first Paralympian athlete of his type to compete at elite 'able body' level. Pistorious, who had been born without either fibula, used prosthetic limbs – called 'Cheetah blades' – to run.⁴ Doubts had previously been raised over the 'legality' of Pistorious's blades. The question was posed whether the technology gave him an unfair advantage. In 2008, following extensive testing and representation before the Court of Arbitration for Sport, he was eligible to qualify for the Olympics.⁵

This brief section on disability sport offers further evidence of the complex and wide-ranging nature of the relationship between sport and medicine. In general, this book has provided a historical overview of a number of the constituent elements present in this relationship since around 1800. The relationship between sport and medicine may not be a symbiotic one but because sport is an activity based on bodily movement – and the association with medicine that this entails – it is unsurprising that this relationship has been continuous since sport emerged as a social and cultural phenomenon. Historical continuities, however, cannot mask the forces of social transformation that have been constantly at work in shaping this relationship. On a broader historiographical point, placing the history of sport and medicine in comparative contexts also reveals how medical practices have differed or converged relative to broader social history of medicine narratives, such as specialization and professionalization. With reference to sport and medicine, three overlapping forces can be identified.

First, there has been the commercial and global expansion of sport, which has provided a demand for medical services and scientific knowledge. Without sport there can be no sports medicine and since the early professional sports and then the growth of international competition stimulated by the so-called Cold War, sports medicine and sports science have become important components in this process.

The second major force at work has been the role of the state. To a certain extent there has been a relatively parallel development in when and how nations have used sport for the purposes of national prestige and to improve the fitness of populations. However, this process in terms of its intensity and the importance bestowed on sport has been subject to each nation's prevailing political culture. At one end of the scale, sport in Britain and America has traditionally been part of a voluntary tradition whereas in the Soviet Union, for example, it was closely controlled by the government. In addition, medical professions have developed along national and political lines, which has conditioned how sports medicine organizations have been funded and ultimately the role they have played.

Finally, the athletic body has evolved alongside changing conceptions of the body's capabilities since around 1800, especially the transition from Galenic

to Western medicine. Initially, the classical Greek body was the model but with the expansion in scientific medicine, the bacteriological revolution and the growth of physiology the body was increasingly seen as a machine that no longer had a limited supply of energy. Due to a closer relationship with science, the potential capabilities of the athletic body increased exponentially.

The modern relationship between sport and medicine emerged out of a growth in physical culture from the late eighteenth century. In Europe gymnastics promoted a growing understanding of the body. In addition, as Dorothy Porter has pointed out for the nineteenth century, health had begun to dominate discourses over social welfare.⁶ The benefits of sport and exercise increasingly blended with concerns over the health of nations and the emergence of the early welfare state. National fitness became a pre-occupation for major Western countries from the late nineteenth century. A healthy population was required both to meet the demands on the working body that industrialization had brought as well as preparation for war. Mass physical education programmes were products of these concerns.

Modern sport was partly a consequence of the cult of athleticism in British public schools where games were seen as character-building in the process of making men. The expanding middle classes appropriated traditional sports, such as football, pugilism and pedestrianism and increasingly codified them and established governing bodies run by gentleman-amateurs. Importantly, they imbued sport with a set of values, especially amateurism, which became the dominant ideology – although not the only one – of sport for much of the twentieth century. British sports were taken elsewhere and amateurism became the main ideology in international sports federations, including most importantly the IOC. Although it was often a more flexible interpretation of amateurism, it provided a framework which other countries could work within and exploit, especially when it came to the Olympics. As a consequence, amateurism was constantly reinvented until the pressures of commercialization and competition became difficult to resist. But it was also in this context that medicine's relationship with sport was shaped with values that would play a significant role in the ideas underpinning sporting ethics.

Sport itself was an important feature of modern life and reflected the shift from economies fixed on production to ones based on consumption. The masses had more time and money to spend on their leisure. Along with America, Britain also pioneered sports commercialization and professionalization. The notion of the professional athlete who worked regular hours for a regular wage was born. But with this lifestyle came unique working conditions and especially the threat and reality of dealing with injuries.

Moreover, the increasing intensity of competition meant greater resources had to be devoted to the training and preparation of athletes. Early ideas of the athletic body were framed around the methods of early trainers and coaches, which were grounded in their own experiences and empirical observations.

Yet coaches were adaptable and increasingly sought and made use of scientific medicine. To a certain extent, based on research on fatigue in the workplace and on the battlefield, the athletic body was increasingly seen as a machine and athletes could be trained to the point of exhaustion. In this sense, sports medicine served a different purpose to most other forms of medicine because the focus here was on bodies which were healthy rather than those that were ill. It also highlighted how ideas of excess for training not only replaced those of moderation but were also part of the sporting discourse.

It may have initially offended amateur sensibilities in Britain but elsewhere there was a rush to exploit the new possibilities. Germany and America were initially in the vanguard but with the onset of the Cold War after 1945 and national prestige at stake, Eastern European countries were the first to exploit science and medicine on a large scale. With sport an arm of the state, a more organized approach was adopted to training and coaching. Countries adopted different methods that have to a certain extent been dependent on national political culture. For much of the twentieth century, state support was limited for British sport, certainly when compared to the Soviet Union and later even Australia. By the twenty-first century, however, British sport at elite Olympic level was just as integrated into the state. And with its adoption of World Class Performance programmes and Long Term Athletic Development strategies – with its eugenic overtones – there is more than a hint of the old East Germany about this approach. The new British approach was also a by-product of sport's growing global reach and commercial power. Because of its media profile and possibilities for political gain, sport was becoming too important for governments to ignore. Moreover, as some elite sports were incorporated within the state machinery they gravitated towards unwieldy bureaucracies that were subject to targets and a culture of managerialism. It is doubly ironic that modern sport was a Western, bourgeois invention and it was Eastern bloc countries who through their state-run institutes sought initially to 'hot-house' athletes, but it is now Western nations who have begun to ape this approach.

At the same time as sport was increasingly appropriating medical science, the medical profession was developing a greater interest in sport. Much of this early interest was personal as many doctors were keen on sport but alongside this they could also see opportunities in sport's expansion. In the West it mirrored a wider political concern of doctors to exclude so-called alternative practitioners and for doctors to ring-fence their own expertise. The specialization of sports medicine has proved problematic mainly because of the opaque nature of the practice and sports medicine itself was continually re-defined. Elite athletes sought specialists in particular fields rather than sports medics who were often generalists. As sporting competition intensified, athletes and sports bodies gradually looked towards sports scientists for a cutting edge; for elite athletes in particular, sports medicine was seen as the key to recovery from injuries.

What about the doctors? In Britain at least, the medical profession was for much of the twentieth century dominated by men and was essentially middle class and conservative in its outlook. These values manifested themselves in a number of ways and were particularly apparent in the relationship between women and sport. Medical opinion fused with social discourse in shaping the nature of female sporting activity. Yet the medical profession also had to respond to social and political change. During the twentieth century the notion of gentlemanly medicine faded as a meritocratic ethos permeated society. Doctors, however, still looked upon themselves as the medical advisor to the nation, something apparent in their highly public campaign to ban boxing. But this campaign was also noticeable for the high moral tone of the arguments and invocation of the idea of 'civilization'. It also echoed wider debates about leisure in which middle-class reformers have looked on disapprovingly at working-class activities.

Finally, it may be worthwhile reflecting on what the relationship between sport and medicine means and its potential consequences. In a stimulating article, David Runciman posed the question, 'Is the rise of the super-athlete ruining sport?' Because of rapidly advancing technology, there was a fear that sport would lose its appeal. Runciman argued that while athletes aspire to:

an ideal of natural human excellence ... there is something increasingly unnatural about athletic achievement at the highest level – it is by definition an abnormal accomplishment – and something even more unnatural about the idea that human beings can keep getting faster ad infinitum.⁷

As a consequence, these 'super-athletes' are extending the gap between the elite and recreational athletes at an exponential rate. While it could be argued that this is the point of elite sport, in increasing their remoteness sport begins to look ridiculous. To a certain extent, sport's 'abnormality' reflects wider debates over the nature of medical power and fears over the influence of an authoritarian medical perspective, which has been associated with biomedicine and a collaboration between doctors and the state. In this sense, elite sport due to the growing influence of medicine and science can be seen in these biomedical terms.

Similar sentiments, however, have been expressed about sport's relationship with commerce for over one hundred years and also with the same sense of foreboding. People are often more likely to see crisis in the present. Adam Smith once said that there is a lot of ruin in a country. Perhaps the same could be said of sport. Thus, while sport has devoted more resources to medicine there is perhaps a danger of presentism due to an over emphasis placed on sport's so-called medicalization i.e., the extension of rational, scientific values in medicine to sport. It offers a doomsday scenario, or a moral panic, where athletes become merely extensions of the research of the doctors and scientists who help them.

A recent aspect of this slightly dystopian outcome has been the emergence of new genetic technologies. With the mapping of the human genome, for example, it has been argued that the implementation of genetic testing in sport rather than giving athletes an unfair advantage will instead make all athletes the same. This 'genetic determinism' is based on the idea that certain body types are suited to certain kinds of sports and has been employed in rugby union and tennis.⁸ Moreover, Miah has argued that genetic testing along with potentially genetic engineering could have important consequences for the human rights of athletes.⁹

There is more than a hint of nostalgia implicit in the construction of such scenarios. In particular, the shadow of amateurism with its notion of fair play hangs heavy. Amateurs had initially considered training a form of cheating. As Heggie has pointed out, 'there has never been a time when people weren't worried that artificial techniques would ruin sport'.¹⁰ And of course sport itself is an artificial construction which has devised its own rules and codes of behaviour. Moreover, there is always the issue of the athlete – the 'patient' – and agency. Athletes are not passive recipients, and can make their own decisions while environmental factors are also important in contributing to the success of athletes. Even in communist countries, athletes were far from the robots often featured in popular discourse; they took part because they were good at it and enjoyed it.

Finally, it may also be worth posing the question where will it all end? As elite athletes are only separated by tiny margins the use of genetic technologies at an early stage, like other methods used to enhance athletic performance, would be significant. How acceptable this would be to a wider public, which understands sport to be – somewhat erroneously – a level-playing field, is equally questionable. It is perhaps further confirmation that ultimately sport at the elite level is an 'unhealthy' practice.