Sports, Medicine, and the Emergence of Sports Medicine in the Olympic Games: The Canadian Example

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Prior to the late 1960s, Canadian Olympic teams did not consistently include a physician or a health care team. The thirty-six medical personnel accompanying Canada’s 265 athletes at the 2004 Olympics games in Athens represent the growth of the sports medicine field in both Canada and at the Olympic games. This paper chronicles and analyzes the changing composition of the Canadian Olympic teams between 1932 and 2004. From 1968 on, the Canadian Olympic roster began to include numerous medical personnel in order to use sport science and medical science to develop higher-calibre athletes, win more medals, and remain competitive with the elite sporting nations of the world. However, the services provided by a nation’s health care team at the Olympic games often duplicate the services offered by the host city, provide competitive advantages to the athletes who use them, and, ultimately, introduce additional inequalities into the Olympic Movement.

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WHEN THE 265 ATHLETES REPRESENTING CANADA at the opening ceremonies of the 2004 Olympic games in Athens marched into the Olympic stadium, thirty-six medical personnel accompanied them in the procession.¹ The presence of the Canadian “health care team” demonstrates the important position sports medicine holds within elite sport systems and its complete integration into the Olympic games. Medical personnel were not always included as part of a nation’s Olympic roster. Indeed, prior to the 1960 Olympic games in Rome, Canadian teams did not consistently travel with any health care personnel, let alone enough medical practitioners to constitute a health care team.² An examination of the changing composition of Team Canada between 1932 and 2004 demonstrates that in an attempt to remain competitive with the elite sporting nations of the world, the Canadian Olympic team expanded to include greater numbers of medical personnel in the hope of using sport science and medical science to develop higher-calibre athletes who would win more medals at international events. The emergence of sports medicine as an essential component of facilitating athletic success in the 1960s led to the inclusion of infrastructure and medical personnel on subsequent Canadian Olympic teams that duplicated services provided by the host country, provided competitive advantages to its athletes, and, ultimately, contributed to creating competitive inequalities at the Olympic games.

The Canadian Olympic Association’s quadrennial report, Canada Competes at the Olympic Games, provides primary accounts of Canada’s involvement at past Olympic games. Each edition, written by Canadian team representatives, managers, officials, chaperones, and medical personnel, includes commentaries on participating at the games, results for each sport in which Canada entered a competitor, and the team’s roster with each representative’s role and specific duties. By compiling the number of athletes representing Canada at each Olympics and the number of support personnel, specifically physicians, therapists, and other members of the health care team, one can identify changes and trends in the composition of Team Canada. Gradual changes in attitudes, policies, and practices led to the integration of medical personnel onto the Canadian Olympic team, and the following three areas in particular contributed to the current practice of bringing large medical teams to the games: 1) the growth of sports medicine as a field of study; 2) the move beyond using the host city’s health care offerings; and 3) the process of rationalizing created advantages and inequalities. The resulting disparity among resources available to each nation at the games compounded the inequality already present in the Olympic Movement.

The Growth of Sports Medicine as a Field of Study

When Baron Pierre de Coubertin revived the Olympic games in 1896, he acknowledged the medical aspects of high-performance sport in one of his lesser-known mottos: Mens fervida in corpore lacertoso. The English translation, “An ardent mind in a well-trained body,”³ reflects the importance of training the mind and the body to excel in sport. As the stress placed on athletes’ bodies during frequent intensive bouts of training leaves them vulnerable to illness and suboptimal levels of health, it is not surprising that a partnership between athletes and physicians emerged to maintain and improve the athletes’ health.⁴
The first stirring of interest in sports medicine in the twentieth century came from a group of German physicians who coined the phrase “sport physicians” in 1904 and organized a sports medicine congress in 1912. International interest in sports medicine can be traced back to a gathering of team physicians in St. Moritz during the 1928 winter games, where the physicians in attendance agreed to resume their informal discussions about sports medicine in a more formal setting later in the year. The resulting congress, held in conjunction with the 1928 summer games in Amsterdam, was a success, attracting 281 physicians from twenty nations and setting the stage for future discussions about sports medicine. Notably, Canada’s contribution to these initial developments was minimal since Canada had not yet begun naming sports medicine personnel to its Olympic rosters, and sports medicine personnel were not yet traveling to the Olympic games.

The German delegation of sports medicine practitioners continued to host congresses on the integration of medicine and high-performance sport and included among their efforts was the organization of an international congress in conjunction with the 1936 Olympic games in Berlin. The 1936 congress, which attracted over 300 German physicians and an additional 400 physicians from more than thirty-five countries, served as one of the first large gatherings of medical professionals interested in sport in which Canadians took part. It also marks the beginning of Canadian physicians’ contributions to the international dialogues and discourses on sports medicine.

At the same games, the Canadian delegation found itself in the presence of a team physician for the first time when the chief coroner of Ontario, Dr. M.A. Crawford, who was in Berlin on a vacation with his family, volunteered his services during the games. Although Crawford was not an official Team Canada member, he offered his medical services to the Canadian contingent. As Canadian Olympic Association official W.A. Fry eloquently noted in his summary of the games, Crawford’s impromptu involvement with the Canadian athletes in Berlin was a “source of greatest comfort and satisfaction to have available day and night throughout the trip the kindly solicitous fatherly attention of one whom the entire team came to hold in such affectionate regard and esteem.” Prior to this unforeseen interaction with a Canadian physician, the Canadian athletes and support personnel expected to rely solely on the services provided by the host city’s organizing committee, free of charge, to meet their health care needs.

While reports from the Canadian delegation in Berlin suggest that physicians attending the games and congress in 1936 were enthusiastic about promoting sports medicine as a respected discipline, former American College of Sports Medicine President H. Royer Collins contends otherwise. He reports that for most North American physicians, interest in sports medicine was more theoretical than practical and that prior to the Second World War, “[P]hysicians considered it undignified to sit on the bench at an athletic contest to take care of the athletes on the field.” But with the end of the war came a change in attitude among North American physicians, and sports medicine developed to the point where it “no longer was undignified for a physician to associate with athletes and become involved in athletic medicine.” Similarly, an editorial in the Journal of the American Medical Association in 1968 claimed that interest in sports medicine grew among physicians because of “the significance given Olympic achievement in this competitive world.” By the time sports medicine gained acceptance as a respected and dignified field of study
in the late 1960s, its initial indecorous reputation was long forgotten, and the role of the sports physician had become a highly sought after position.

British physician Tim Noakes argues that three independent events in the 1960s inspired physicians to take note of the medical aspects of sport. These events include: 1) the realization that drug use in sport was both prevalent and dangerous; 2) the selection by the International Olympic Committee (IOC) of Mexico City to host the Olympic games in 1968 despite its high altitude and negative effects on health;11 and 3) the strong showing of the German Democratic Republic at the 1968 Olympic games, which was attributed to the country’s innovative training techniques. Each of these events created interest among medical professionals as sport organizations sought out their services to help elicit desirable physiological responses from elite athletes under variable conditions.

Ironically, one of the unhealthiest practices in sport helped solidify the field of sports medicine. The tragic deaths of cyclists Knud Jensen and Tommy Simpson at the 1960 Olympic games and the 1967 Tour de France, respectively, were attributed to performance-enhancing drug use and forced the sports world to acknowledge that doping was “threaten[ing] both the stability and integrity of sport.”12 The danger that doping brought to sport helped launch the sports medicine field, as individuals with knowledge of both sport and medicine were needed to ensure athletes remained healthy and did not jeopardize their health using performance-enhancing substances. Concerns stemming from the air quality in Mexico City and the health risks the city’s pollution posed to athletes competing at the games also motivated organizers to seek advice from the medical field. Furthermore, several Eastern European nations claimed their extensive knowledge of sport science and ability to use medicine to improve athletic performance facilitated the unexpected success of their athletes. Medical personnel were thus the logical people to consult to gain similar information in North America.13 In response to the new health concerns faced by athletes in the 1960s, interest in sports medicine grew in Canada among medical practitioners, and representatives began appearing on Olympic rosters soon after.

The Move beyond Using the Host City’s Health Care Offerings

The concept of a team of health care professionals that traveled alongside the Canadian delegation to the Olympic games was unheard of prior to the establishment of the field of sports medicine in Canada in the 1960s. Masseuses Murry McNear and Torchie Pedo, who accompanied the Canadian track and field team to Berlin in 1936,14 were the only two medical personnel to hold positions on an official Canadian Olympic team roster until 1956.15 At this time, Dr. Paul Hauch, who volunteered his services as the official swimming manager and the unofficial team physician, became the first physician to appear on a Canadian Olympic roster; however, his official position was managerial, not medicinal, in nature.16 By the next summer games, the Canadian Olympic team would expand to include physicians and other medical professionals in their official capacities as sports medicine practitioners.

The team representing Canada at the summer games in Rome in 1960 included a physiotherapist and Hauch, who was relieved of his managerial duties of the previous summer games to focus exclusively on caring for the athletes’ health.17 Due in large part to Hauch’s campaign for greater medical representation on Canada’s Olympic rosters, the
Canadian contingency grew to include even more sports medicine practitioners soon after. Hauch’s recognition that he could not treat all 142 athletes representing Canada at the 1968 summer games alone led him to recommend that future teams include one additional physician per every one hundred athletes, and that the traditional women’s team chaperones be replaced by nurses, who could not only supervise the women athletes but also see to their physical needs. Interestingly, when the number of physicians and other medical personnel began to increase, the role of the chaperone became obsolete; from the 1970s on, Canadian Olympic teams no longer appear to have included official women’s chaperones.

While the Canadian delegations at the 1960, 1964, and 1968 Olympic games included one or two medical personnel, the thirteen medical professionals named to the Canadian team at the 1972 summer Olympic games in Munich marked the introduction of a health care team capable of rivaling the host city’s offerings. The upward trend in the number of health care personnel accompanying Canadian teams in each successive Olympiad after 1968 is noteworthy, but what is of greater interest is why this occurred when host cities offered similar services in their Olympic villages and venues. The provision of complete, free, and accessible medical services by the host nation seems to negate the need to include a health care team on a nation’s roster.

Functional makeshift hospitals, staffed with a wide range of medical specialists, are the norm at the Olympic games and, for many decades, the Canadian Olympic teams utilized and praised the host city’s medical facilities, personnel, and services. For example, the chaperones of the Canadian women competing at the 1932 Olympic games in Los Angeles, the distinguished former athletes Alexandrine Gibb and Myrtle Cook, reported that the doctors, nurses, and medical facilities provided in the Chapman Park Hotel, where the athletes lived during the games, met and surpassed the needs and expectations of the Canadian women’s team. At the following summer games in Berlin, the organizing committee provided free dental, medical, and surgical services to any participant in need of such assistance, even treating old injuries and conditions not sustained at the games. Nonetheless, most Canadian athletes opted for Crawford’s tailored care and services instead of those offered by the hosts, despite the presence of a full medical clinic, staffed by doctors and nurses twenty-four hours a day, located within the athletes’ dormitories.

The prevailing thought appears to have been that Canadian athletes would benefit from receiving care from Canadian physicians, whom they knew and trusted, rather than from foreigners whose techniques, mannerisms, and treatments might differ from those to which they had become accustomed. It is important to note that this thought, which contains traces of xenophobic undertones, was prevalent even before the field of sports medicine was established in Canada. Yet if qualified medical personnel could treat ill and injured athletes and officials free of charge on site, one might wonder what possessed the Canadian team to bring its own people and set up its own clinics.

The host city is responsible for providing medical services at the Olympic games, but the by-law to rule 42 in the Olympic Charter indicates that the hosts must also cover the costs associated with providing transportation, board, and lodgings for each team’s representatives, including their health care personnel. Some might see the duplication of
services required of the hosts as an unnecessary waste of resources and a burden on the host city. While having private team physicians, therapists, and other health care personnel available for personalized consultations undoubtedly provides some advantage to a team, it seems unlikely that any purported advantage could be quantified or objectively measured. However, it is important to note that a nation choosing to include a health care team on its roster was, and still is, free to do so as long as the provisions set forth in the IOC’s Rules and Regulations Eligibility Code and Olympic Charter are respected.

Following the rise in the number of sports medicine personnel accompanying Olympic teams in the late 1960s and early 1970s, the IOC mandated that nations could bring “only competitors and those serving the competitors with definite duties” in the 1971 edition of the Rules and Regulations Eligibility Code. Each nation was permitted to appoint one doctor to its roster, and teams bringing more than fifty competitors could bring an extra doctor for each additional one hundred competitors, up to a maximum of four. In addition, rosters could include a nurse, a masseuse, and a “female official” or chaperone for every two sports in which female athletes competed, and those nations with more than one hundred athletes were permitted an additional nurse and masseuse for every fifty competitors.26 The number of medical personnel a nation could include on its Olympic roster was expanded in the provisions set forth in the 1979 Olympic Charter. Rule 41 and the by-law to Rule 41 stated that teams could include four medical personnel for every twenty-five competitors, six medical personnel for every fifty competitors, and so on.27

Revisions to the Olympic Charter in 1987 included the placement of an upper limit on the number of medical personnel a nation could include on its roster. In this version, the by-law to Rule 37 was modified to read: “The quota shall be: . . . Medical personnel (doctors, nurses, masseurs) 5 for 25 competitors and 1 additional for every other 25 competitors to a maximum of 24.”28 Canada’s delegation of nineteen medical personnel at the previous Olympics in Los Angeles, which included a chief medical officer, a nurse, five physicians, and twelve therapists, fell within these limits.29 The IOC’s Sport Medicine Manual contains a formula for determining the number of additional personnel, including medical practitioners, a National Olympic Committee can include on its roster and the Olympic Charter gives the authority to individual International Federations to determine the number of non-competing team members each nation can include on its roster.30

Athletes’ reliance on the medical services provided by the host city is much lower now than before the growth of the sports medicine field in the 1960s. Data collected prior to the 1984 games in Los Angeles by the organizers projected that “approximately 70% of the Village inhabitants [would] seek medical treatment during their stay,” based on records from the 1932 games in Los Angeles where 473 athletes used the medical services provided by the hosts.32 However, as data collected at the 1996 games in Atlanta shows, the percentage of athletes using the host city’s medical services is no longer that high. Of the 10,318 athletes competing in Atlanta,33 only forty-three sought treatment from the medical and dental facilities provided by the Atlanta Committee for the Olympic Games at the Georgia Institute of Technology, Emory University, and on-site medical facilities.34 When only 0.4 percent of all competitors utilized the host city’s medical resources in 1996, compared to 70 percent in 1932, it is clear that the Canadian team is not alone in bringing its own medical personnel and equipment to the Olympic games.
Permitting nations to include full health care teams on their Olympic rosters decreases the demands placed on the host city’s medical services and allows organizers to reallocate these resources to meet the needs of other individuals and groups. With this in mind, the Sydney 2000 Organizing Committee prepared a medical program for their games that boasted 4,000 health care professionals but focused most of their efforts on medical surveillance to detect trends in sickness and outbreaks in disease, rather than the primary care of athletes. The intention of the Committee was that the 4,000 individuals would also assist the “already present medical team from the particular National Olympic Committee or provid[e] the sole source of care for those countries that do not bring their own medical team.” Thus, by the year 2000, the host city’s medical services had been reduced to a service for spectators and countries unable to bring a complete medical team.

Olympic games consistently attract over ten thousand athletes, fifty thousand volunteers, and hundreds of thousands of fans. With large numbers of people gathering in one location, precautionary measures are necessary. Therefore, hospitals, polyclinics, and first-aid stations are essential to ensure the safety of the athletes, officials, and fans alike. Retired Canadian Forces Colonel William Shuler, who oversaw the medical services provided at the 1980 winter Olympics in Lake Placid, notes that when organizing medical programs for large-scale events, it is essential that enough medical personnel are present on site to deal with unexpected circumstances. Reflecting on the possibilities one must prepare for when coordinating such events, Shuler comments:

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\text{[C]ontingencies include disease outbreaks among visitors, problems from exposure to sun or cold, unusual amounts of exercise at [high] altitude . . . , travel endangered by ice and snow, and although no one likes to talk about it—the dark shadow of possible terrorism attempts that has hung over the Olympics since Munich, Germany.}^{36}
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It is vital that organizing committees provide enough medical coverage to meet the needs of the athletes, officials, and spectators, and deal with unexpected catastrophes. However, it remains unclear if each nation competing at the Olympic games needs to bring its own delegation of medical personnel and equipment, or if the services provided by the host city would suffice.

**Rationalizing Advantages and Inequalities**

From the very limited medical resources and personnel included on Canadian Olympic teams prior to the 1960s, to the nearly exponential growth occurring afterward, Canadians have always wanted what is best for Canadian Olympic athletes. With the public’s growing interest in Olympic sports and their desire to see Canadian athletes emerge victorious, the use of science to elicit greater athletic performances has flourished and was an essential factor in the growth of the sports medicine field in Canada. Results became the priority of the nation and Canadians took pride when their athletes succeeded internationally. As Donald Macintosh, Tom Bedecki, and C.E.S. Franks note in their work on Canadian sport politics:

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The \text{high visibility of international sports events, the prominent role that Canada played in hosting the 1976 summer Olympics and the 1978 Commonwealth Games, combined with the assertion by provincial governments of their responsibilities for mass fitness and sports programs, led the federal government to concentrate on elite international sport.}^{37}
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The influence of post-war internationalism and Cold War rivalries also played “powerful roles[s] in creating a favourable climate for federal government intervention in sport in Canada,” which translated into increased research into the sport and medical sciences to ascertain effective methods of enhancing training and performance.

The thirty-six-person health care team of 2004 is thus a result of both the nation’s desire for Canadian athletes to win medals and the Canadian sport system’s response to government policies outlining goals for elite sport programs. Studies conducted on the needs of the national sport governing bodies in Canada, prior to the Calgary games in 1988, showed that the explicit objective of all national sports federations was “performance excellence” and that focusing on sports medicine was one way to achieve success. Sports medicine ranked fourth in the most used disciplines of sport science, behind physiology, sport psychology, and biomechanics but was considered the discipline with the most potential to help produce elite athletes. Approximately 65 percent of national sports federations in Canada felt that sports medicine could assist their athletes in achieving success, predominantly through better equipment design, more efficient injury prevention techniques, and effective treatments for sport-specific injuries.

With the establishment of the Canadian Academy of Sport Medicine (CASM) in 1970 came the standardization of procedures for selecting medical personnel to accompany Canadian national sports teams in international competitions. Following guidelines outlined in the document *Health Care Team Selection Principles*, which took effect from 29 October 2004, thirty-six medical practitioners were selected as members of the Canadian Olympic team for the summer games in Athens. Among those volunteering their medical expertise and reporting to the Chief Medical Officer (CMO) and the Chief Therapist (CT) were an assistant CMO and CT, six physicians, six massage therapists, eight physiotherapists, six athletic therapists, two chiropractors, a nurse, a sport psychologist, an exercise physiologist, and the clinic manager.

When competing at what might be the pinnacle of an athlete’s career, being treated by a medical team one has previously built a rapport with is undeniably comforting to an athlete. Doing so also eliminates language and cultural barriers that might arise between local medical practitioners and foreign athletes. Fostering a relationship built on mutual understanding, trust, and respect thus seems impossible if the only option an injured or ill athlete has is to receive treatment from an Olympic polyclinic or hospital. Athletes might experience what borders on professional xenophobia which, broken down into its Greek roots, *xenos* (a foreigner or stranger) and *phobos* (a fear), describes in this context the fear of receiving treatment from an unknown, foreign health care professional. Whether an athlete’s preference to receive treatment from known medical professionals is reducible to a preference for treatment from a familiar figure or a fear of foreign medical personnel is significant as the games also seek to promote unity and friendship, not just competition.

Including medical personnel on each nation’s Olympic team helps the coaches and trainers decide if they should recommend an injured or ill athlete withdraw from competition to prevent further injury or if the athlete can continue participating. A justification for the inclusion of health care teams on Olympic rosters hinges on the fact that consulting only one physician about an athlete’s fitness and ability to compete relies too heavily on one person’s opinion; instead, “these decisions [should be] made by a committee, whose
members consist of the head physician, the physician volunteer assigned to that athlete, the coach, the team trainer, and the administrator of sport.”44 Putting the paternalistic nature of this suggestion aside, it is important to note that it is in an athlete’s best interest to have many knowledgeable people assess the extent of an injury and make appropriate recommendations rather than taking the advice of one person. Furthermore, as physician Charles Meyer argues, unlike a race car driver who can replace a faulty engine in his or her car, athletes’ bodies are irreplaceable and injury often means an athlete must withdraw from competition: hence, “the elite athlete’s machine is her body, and it’s the sports physician’s job to maintain and mend it.”45 The stress and strain that sport places on the body makes it seem reasonable for teams to request the presence of highly trained professionals who are familiar with the athletes and their medical histories at the Olympics.

During the games, each team tries to provide a comfortable and supportive atmosphere for its athletes in order to assist them in their quests for victory. Nations also want to ensure their athletes are not disadvantaged compared to their competitors; hence, they try to keep information about minor injuries closely guarded.46 Knowledge of an athlete’s injury or weakness could provide a substantial advantage to his or her competitors, particularly in the combative sports and events requiring considerable strategy. The director of medical services at the Salt Lake City games in 2002, Ginny Boncamp, concurs noting:

Unless a condition is life threatening or requires surgery, they try to take care of their athletes themselves. That way, no-one knows the extent of the athlete’s injury and it doesn’t give competitors an edge. But if a country is sending only a few athletes or has limited funding, they will use us exclusively.47

While Boncamp acknowledges the competitive advantage an injured athlete’s opponents may gain from knowledge of the athlete’s injury, she does not mention the competitive disadvantage athletes representing nations with delegations not large enough to bring complete medical teams to the Olympics face.

The discrepancy in the resources available to athletes from different countries at the games is problematic because of the inequality it fosters. Ethical issues arise when athletes from nations without full health care teams present at the Olympics must make do with fewer resources than athletes from nations with complete, personalized, medical resources. The number of medical personnel Canada currently sends to the Olympic games is greater than the number of athletes listed on many countries’ rosters. When a nation only sends two athletes to the games, sending a medical team of more than ten health care professionals seems absurd; yet, the two athletes could benefit just as much from having a variety of perspectives represented through a large medical contingent as any athlete from a large delegation could. In many cases, willing medical personnel are forced to stay at home if too few athletes qualify to compete.48

American physician Allan Bruckheim, who served on the United States health care team in the 1970s, recalls that smaller delegations often made arrangements with larger delegations to use the larger nation’s medical services if their athletes became ill or injured.49 While the thought of a larger or more affluent nation sharing its resources with a smaller delegation evokes thoughts of goodwill, friendship, and the ideals of Olympism, nations with health care teams present at the games are not obliged to share and most do not. Inequality exists because not all nations have access to the same resources, the same

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levels of personalized treatment, and the same degree of privacy. Undoubtedly, this is a widespread problem within the Olympic Movement that goes beyond the scope of medical care and supervision at the games. Finding a practical or pragmatic way of equalizing the resources available to all athletes is likely to be impossible without addressing the larger social problems surrounding distribution of wealth that contribute to the inequalities in the first place.

If the medical services offered by a nation's exclusive health care team merely duplicated the services offered by the host city, nations bringing their own medical personnel would be much less problematic: however, this is not the case. Individual health care teams can offer services above and beyond those provided by the host city by tailoring their services to the needs of individual athletes, providing additional privacy and offering culturally sensitive treatments and advice. While it is easy to criticize nations that bring full medical staffs with them to the games as being superfluous, elitist, or unfair, it is important to remember that the individuals who make up the health care teams have a professional interest in their athletes' health, a nationalistic interest in seeing them excel, and “have selflessly given of their skills and energy to a field they love dearly.” Canada's Olympic health care professionals seek to provide the best treatment they can for Canadian athletes; they do not seek to prevent other athletes from receiving treatment. Thus, while they are not outwardly disadvantaging competitors who must rely on the host city's medical services, they appear to be providing an advantage to their own athletes.

The popularity of the Olympic games, in conjunction with the government and the public's demands for scientific and medical knowledge to improve athletic performance in elite sport, paved the way for the integration of medical personnel onto the Canadian Olympic teams. Sports medicine personnel are undoubtedly an essential component of the Olympic games. However, when they serve only athletes from a specific country, their exclusive focus on those athletes puts athletes from countries without medical teams at the Olympic games at a competitive disadvantage. Host cities make valiant attempts at diminishing the resulting inequality by providing free, comprehensive medical services to those who opt to use them. Nonetheless, these services do not compare to the services rendered by team medical personnel who have built up a rapport with their athletes and can offer tailored care. How to eliminate the competitive advantage athletes from countries with larger health care teams gain from having their team physicians and medical staffs present at the Olympic games is an ethical dilemma that requires further contemplation and analysis.


8Ibid., 5-6.


14Fry, Canada at the XI Olympiad 1936, 145.

15See the team rosters included in the editions of the Canadian Olympic Association’s Canada Competes at the Olympic Games published between 1936 and 1956 for documentation of the lack of medical personnel on Team Canada during this time period.


18Farmer, Cook-McGowan, and Radford, Canada Competes 1956, 139.


21E.H. Radford and F.J. Shaughnessy, Jr., eds., Canada at the Olympic Games: Sapporo Munich 1968-1972 (Ottawa: Canadian Olympic Association, 1973), 69. The increase from a physician and a physiotherapist at the 1968 Olympic games to two doctors and two physiotherapists at the 1972 winter games in Sapporo, and thirteen medical personnel at the 1972 summer games in Munich (including five physiotherapists, six doctors, a nurse, and a chief medical officer) suggests a turning point.


23Ibid., Canada at the XI Olympiad 1936, 6.

24Ibid., 85.


27International Olympic Committee, Olympic Charter 1979 (Lausanne, Switz.: International Olympic Committee, 1979), 50. The list continues: seven medical personnel for seventy-five competitors, eight for 100, ten for 150, twelve for 200, fourteen for 250, sixteen for 300, seventeen for 350, eighteen for 400, nineteen for 450, and twenty for every 500 competitors.


41<http://www.casm-acms.org>, p.1 [01 April 2005]. The organization was created June 8, 1970, to deal with the specific medical problems the Canadian team faced at the 1968 Mexico City Olympic games. Their stated function is to “provide medical care to elite athletes at international events, information, and expertise in the art and science of sport medicine.” Other priorities included treating injuries, advising athletes of their nutritional needs, assessing venues for safety, and educating athletes on inadvertent doping.


48Chricton, “Putting Together a Medical Team,” 612.
