The Committee on Drugs unites with the Joint Committee on Physical Fitness, Recreation, and Sports Medicine in condemning the use of drugs to improve athletic performance. However, the Committee on Drugs would like to clearly distinguish between the promiscuous use of drugs and their pharmacologic use to control a specific disease state enabling the adolescent to participate in sports, for example, the use of insulin for diabetes, anticonvulsants for epilepsy, digitalis for heart disease, or bronchodilators for asthma.

Children and adolescents with handicaps should be given the same advantages as other children, including participation in athletic activities. Athletes with medical conditions controlled by drugs should not be placed in the same category as youths taking drugs for other purposes, and there should be minimal, if any, restrictions imposed on them. One recent example of the type of restrictions which should not be imposed is the athlete with exercise-induced bronchoconstriction who was disqualified in the 1972 Olympics in Munich because he used a bronchodilator prescribed by his physician. Exercise-induced bronchospasm is a common handicap of allergic youth, and may occur in between 60% and 80% of individuals with allergic respiratory distress. Such bronchoconstriction can be modified by the administration of theophylline, theophylline ephedrine combinations, or cromolyn sodium. The Committee on Children with Handicaps also recommends that children with asthma participate in sports and physical education and that every effort be made to minimize restrictions.

At the annual meeting of the American Academy of Allergy in Washington, D.C., February 14, 1973, the following resolution was approved unanimously: "Participants in competitive athletics with asthma and other allergic conditions should not be disqualified because of the use, with medical supervision, of therapeutic doses of ephedrine before and during athletic competition."

The Committee on Drugs endorses this resolution by the American Academy of Allergy, and reaffirms the position that it is the physician's obligation to prescribe medication to enable a youth with a physical handicap to lead a normal life, including participation in recreation and competitive athletic events. The Committee condemns the promiscuous use of any drug in attempt to "better" the normal adolescent's performance.

REFERENCES

ACETAMINOPHEN POISONING


SIR GEORGE FREDERIC STILL ON THE CHILD'S TEMPER

Sir George Frederic Still (1868-1941), one of the greatest figures of British pediatrics, wrote, in addition to his superb textbook, a largely unappreciated book entitled Common Happenings in Childhood (1938). In this charming book consisting of essays, studies and stray thoughts about everyday phenomena of a child's life, Still had this to say about temper as seen in children.

“This is not a homily, nor is it philosophic discourse de moribus, it is just a collection of stray thoughts upon temper, especially as seen in children.

When we speak of being 'in a temper' we usually mean a bad temper, but temper in itself has no such one-sided significance, there is good temper as well as bad temper. I am no psychologist and shall not attempt to define temper in terms of psychology, indeed a study of works upon that subject rather suggests that the psychologist knows nothing about temper. He makes great play with the emotions, e.g. anger, but he has nothing to say about that attitude of mind which we call bad-tempered or good-tempered. We all know what we mean by these terms: on the one hand, the sullen, irritable, contrary-minded, passionate; on the other, the bright, cheerful, responsive, 'not easily provoked.'

A stray ebullition of anger or irritation is not necessarily an indication of bad temper, by which we mean rather an habitual tendency. We all have our flash-point of anger or irritation, but in some the flash-point of irritation is lower than the average: these are they whom we call bad-tempered.

How far is temper, whether good or bad, of antenatal origin? In other words, is it congenital or is it acquired? And if congenital, how far does heredity play any part in it?

Any one who has large experience of infants will, I think, admit that at a few months old differences of temper are already manifested. We are all familiar with the bright jolly baby of 4 to 5 months old, who is hail-fellow-well-met with everybody, has a smile for all the world, takes life as it comes, and regards everything as the best joke going; and his antithesis, the baby whose face puckers up to the cry directly you look at him, who is continually fretting because he wants this, that, or the other, or doesn't want it, and in general takes a gloomy view of life. It seems to me that all stages, in infancy as well as in later years, life has its Democritus and its Heraclitus, its laughing philosopher and its weeping philosopher. Certainly these differences manifest themselves so early that it is difficult to believe that they are not congenital. I am much of the same mind as that shrewd observer, The Autocrat of the Breakfast-table, 'Little snapping turtles snap—so the great naturalist tells us—before they are out of the egg shell. I am satisfied that much higher up in the scale of life character is distinctly shown at the age of two or three months'; so says Oliver Wendell Holmes.'

NOTED BY T. E. C., JR., M.D.

REFERENCE

THE ATHLETE AND MEDICATION

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