

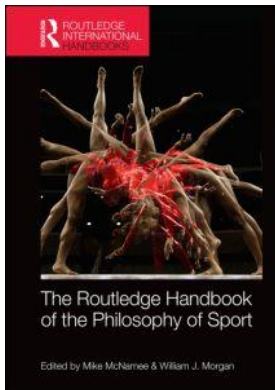
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DISABILITY AND PARALYMPIC SPORT PHILOSOPHY

Steve Edwards and Mike McNamee

Introduction

Relatively little attention has been given to what has variously been called sport for the disabled, sport for athletes with disabilities, sport for athletes with impairments or Paralympic sport, in contrast to the mainstream forms of sport for able-bodied persons. The heterogeneous nomenclature of the limited literature that exists betokens conceptual, ethical and political dimensions of debates for persons with disabilities. In this chapter, we focus on the development of these sport forms, with particular – although not exclusive – reference to Paralympic sports that comprise the quadrennial Paralympic Games. The Paralympic Games, organised by the International Paralympic Committee, are the analogue of the Olympic Games. Although their constitutive activities and the classifications of competing athletes within them are a matter of contestation and debate, they represent the most popular forms of sports for athletes with disabilities or impairments. Other forms and organizations are noted by way of context in the first section, before moving on to discuss issues of classification and identity, and the underlying conceptions of health, ability and disability itself.

Understanding the world of Paralympic sports first requires quite considerable investment in the philosophy and taxonomies and classifications concerning disability and impairment. Having discussed these conceptual issues, the chapter proceeds by discussing three of the most prominent ethical issues: doping (including ‘boosting’), therapeutic use exemptions, fairness of competition, and elective amputation.

Historical landmarks for disability sport

The first disability sports group to mobilise themselves were deaf athletes (Tweedy and Howe, 2011). In 1888, the Berlin Sports Club for the Deaf was formed (Gold and Gold, 2007). It took more than a quarter of a century for the establishment of an international society for deaf athletes in 1922. In a move that foreshadowed later Paralympic Games, the first two International Silent Games were held following the 1924 Paris and 1928 Amsterdam Olympic Games (Tweedy and Howe, 2011). A decade later, in 1932, the British Society of One-Armed Golfers was formed (Brittain, 2010). The first systematically organised games for persons with disabilities occurred in the UK in 1948 and, when joined by Dutch athletes four years later, it

can be said that the Paralympic movement began in earnest. Over time, the Paralympic Games have become parallel games and not merely as somehow lesser to their longer standing and illustrious counterpart, the Olympic Games. Just as the Baron Pierre de Coubertin was the spearhead for the development and internationalisation of the Olympic Games, it was Dr Ludwig Guttmann, a German-Jewish medic escaping the rise of Nationalist Socialism in his fatherland, who in 1948 inaugurated the Stoke Mandeville Games for athletes with disabilities, including athletes mainly from the UK but also the Netherlands. It is widely agreed that this was the birth of the Paralympic movement generally and the Paralympic Games specifically (International Paralympic Committee, 2011).

Today, new sports forms are being devised to test and perfect the athletic skills and character of athletes with a disability. While there is much that unites the different sports forms and their athletic contestants, there are genuine and interesting aspects of Paralympic sports that have gone relatively unnoticed by philosophers (Jespersen and McNamee, 2009). In able-bodied sports, the nature of contests, their organisation, rules and classification systems, have evolved over thousands of years from their Western roots in Ancient Greece. Paralympic sport, by contrast, is a relative newcomer to the world of elite sports. It has yet to probe, let alone resolve, many of the conceptual and ethical issues that arise therein. These issues relate across the whole spectrum of Paralympic sports, from the organisation of events, their marketing and promotion, to the more obvious dimensions of participation and officiating in them.

The contrast with Olympic sports in this regard ought not to be thought of as too sharp, however, especially in the light of the Beijing Games of 2008, which was the first time both Olympic and Paralympic bids were conjoined in the bidding process and brought the games much closer together in terms of organisation and promotion. This is not to say that conceptual and ethical issues are absent from the Olympic Games. Cheating, doping, and foul play – definitions of which presuppose some concept of justice – are everywhere to be found in just about all sports at elite levels. There is no reason to think that Paralympic sports would be an exception, human nature being what it is. Moreover, there remain thorny legitimacy issues regarding sex verification that give athletes, administrators, medics and philosophers problems. Nevertheless, these represent rather minor exceptions to the usual business of Olympic sports. It is, however, often far from clear at times who should be competing against whom in the Paralympic Games, as well as in disability sports in general. In Olympic sports, contestants are typically divided according to sex (for example, in athletics, field hockey and football) but also sometimes according to weight (for example, in boxing and judo). Why this is so is partly historical and partly logical. Sometimes the rationale is clear and justified while at other times it is not. At times, sex-segregated sports are organised on grounds of prevention of harm and, at times, this argument extends to competitions with same-sex contestants. At other times, sex is irrelevant to the performance of activity (for example, in equestrianism), where sex differences are thought not to offer unfair opportunities to win the contest. In Paralympic sport, by contrast, disputes as to who should compete against whom are almost ubiquitous. In this philosophical contribution, we therefore spend considerable time and attention marking conceptual distinctions as to the nature of disability, the arising issues of eligibility and classification that are at the centre of Paralympic sport. We then discuss three, among many, key ethical issues regarding doping, therapeutic use exemptions and healthcare rights for Paralympic athletes.

Issues of classification and eligibility

It is clear that all Paralympic athletes, in order to compete in the Paralympic Games, must have a disability (or more strictly speaking, an impairment) at the time of competition. Precisely who

counts as being disabled is not at all clear. It is sometimes reported that around ten per cent of the world population may be considered disabled. Clearly, however, an appreciation of this statistic begs questions as to the criteria for what constitutes 'disability' itself. It is necessary therefore to consider some basic conceptual issues regarding who may be considered a 'Paralympic athlete'.

The International Paralympic Committee (IPC) states that a necessary condition of being eligible to compete in Paralympic sports is that the athlete must have an impairment and, importantly, that the impairment must 'lead to a permanent and verifiable activity limitation' (International Paralympic Committee, 2007, p. 10). This statement of eligibility employs key concepts – 'impairment/activity limitation' – that are central to the very idea of Paralympic sport. In this section, their meanings are unpacked.

Readers familiar with attempts to create a taxonomy of disability in general will recognise the terms 'impairment' and 'activity limitation' as deriving from a specific theoretical perspective. To appreciate the full significance of these terms, however, it is necessary to understand alternative and sometimes competing ways in which scholars and scientists have tried to capture the meaning and experience of disablement in ways that are theory laden. The first systematic attempt to create a taxonomy of disablement was undertaken by the World Health Organization (WHO) in 1980, in their publication *The International Classification of Impairment, Disability and Handicap* (ICIDH).

According to the ICIDH, disease is said to lead to impairment, which in turn can lead to disability, which can further lead to what was then described as a 'handicap'. Moreover, 'Impairment: In the context of health experience, impairment is any loss or abnormality of psychological, physiological or anatomical structure or function' (WHO, 1980, p. 27).

Impairments are said to arise at the level of parts of the body (WHO, 1980, p. 28). Thus, Oscar Pistorius properly contested Paralympic category T43, since, owing to a congenital disease, he was born without fibulae and consequently his legs were amputated just below the knee when he was 11 months old. Since lacking fibulae counts as an abnormality of anatomical structure, it is an impairment according to the WHO definition. Nevertheless, it should be noted that, according to the ICIDH taxonomy above, it may not follow necessarily that Pistorius should be classified as disabled; more is needed than the mere presence of an impairment. The ICIDH definition of disability holds that: 'Disability: In the context of health experience, a disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being' (p. 28).

Whereas impairments arise at the level of 'body parts', such as organs, disabilities are said to arise at the level of the whole individual (WHO, 1980, p. 28). Thus, impairments are properly attributed to body parts and disabilities are properly attributed to persons. Continuing with the example of Pistorius, we can say that the relevant body parts include his legs but, if one were to attribute disability to him, this would occur at the level of the person – namely Pistorius himself – as opposed to one (or more) of his impaired body parts. Thus, one would say it is the person Pistorius that is disabled, not his legs, shins nor any other part of his body.

The idea of a disabled athlete

In what sense, if any, are highly performing Paralympic athletes to be thought of as disabled? Consider the case of Aimee Mullins, a double-amputee athlete and long-jumper who, in 1998, set world records in the 100-metres, 200-metres and long-jump. How is it that an elite sports-woman can be said to be disabled? Like Pistorius, she was born with fibular hemimelia and

required transtibial amputation. Staying with the ICDH classification, it is evident that, without the use of prostheses she would be unable to carry out the normal human function of walking unaided. Specifically, Mullins would lack an ‘ability to perform an activity in the manner or within the range considered normal for a human being’ (ibid.). As with impairment, the definition of ‘abnormality’ (and normality itself for that matter) relied upon in the ICDH is a biostatistical definition. This understanding of disability is often called, rather loosely, ‘the medical model’ (DePauw, 1997). It should be noted, however, that this is a somewhat crude essentialising of a variety of beliefs and norms about the nature of the human being in conditions of disease, health and illness, and that bringing them together under one label – although convenient – masks the inevitable heterogeneity of views belonging to medical professionals around the globe and crossing distinctions such as primary and secondary care, private and public health care, general practice versus high-tech medicine, and so on. Consistent with the ICDH classification, the medical model of disability is predicated on the belief that there is a causal relationship between a person’s impairment and their disability; it is therefore an outgrowth of the biomedical model of health. In a series of essays, widely regarded as classics in the philosophy of medicine, Christopher Boorse (1975, 1977) argued that health was conceptually the equivalent to ‘normal functioning’. Health, within his theory, is understood as ‘species-typical functioning’ that occurs normally in the absence of disease or impairment. His account is deeply sympathetic to the medical professions’ dominant self-understanding, techniques and ideologies. Moreover, it is positivistic in spirit. For Boorse, normal functioning is a matter of objective fact that can be determined without reference to the views of the person whose health or even, by extension their disability, is in question.

The WHO schema is in sympathy with the medical model and with Boorse’s general theory. Thus, persons are considered normal or abnormal in relation to a reference class (human beings at the same stage of chronological development) who are conceived of as a class with a normal distribution of human functioning. So both Mullins and Pistorius would be described as disabled according to the ICDH classificatory system. Hence, according to the schema above, disabilities are ultimately consequences of disease; disease leads to impairment, which leads in turn to disability.

The fourth category in the ICDH (besides disease, impairment and disability), is handicap, which is defined as follows:

In the context of health experience, a handicap is a disadvantage for a given individual, resulting from an impairment or a disability, that limits or prevents the fulfilment of a role that is normal (depending on age, sex and cultural factors) for that individual.

(WHO, p. 29)

As mentioned, impairments are properly attributed at the level of *body parts* and disabilities at the level of *persons*, so it is said that handicap implicates a level beyond these, namely that of *social phenomena*. For, in contrast to the other two consequences of disease, this category makes explicit reference to social and cultural factors. The category ‘disability’ involves statistical comparison with other humans but not with reference to specific social or cultural norms. (Although the term ‘handicap’ is still used nowadays around the world, notably in Francophone and Scandinavian countries, in the English language, it is generally considered disrespectful.) For the WHO, a disability which ‘limits’ in the sense of ‘hinders’ ‘the fulfilment of a role that is normal’ amounts to a handicap. In the context of Paralympic sports, it is clear that amputee athletes have impairments that lead to activity limitations; for example, in their ability to run

(unaided by prostheses). In the non-sports world, ambulatory limitations may be overcome by use of wheelchairs and, in turn, the use of ramps as opposed to stairs, and so on. The adaptation of the social environment has become more widespread, although is far from universal. It is, therefore, less clear that being unable to walk limits or hinders one's opportunities to fulfil a role that is normal to the degree that it once did. Nevertheless, one can appreciate that the WHO definition captures the viewpoint that those who cannot walk are, to a certain extent, handicapped in some way. Philosophers and sociologists have nevertheless, developed robust criticisms of the WHO definition (Oliver, 1990, 1996; Morris, 1991).

Indeed, critics (Oliver, 1990; UPIAS, 1975) have rejected completely the idea that disability and handicap are 'consequences of disease'. Commentators who promoted what became known as a 'social model' of disability argued against the medical model, that the causes of disability lie in the social environment and not in the individual person, as is presupposed in the WHO definition. Therefore, the ICIDH classification is itself considered to be deeply flawed. By locating the cause of disability in the individual concerned, the definition paints far too crude a picture of the relevant causal factors. However, it should be recognised that the WHO taxonomy has been key to the development of the Paralympic sports organisations, since its categories have been considered sufficiently robust to establish a way of comparing one athlete against another to ensure a fair competition – albeit it in a sometimes crude fashion (Howe and Jones, 2006).

Further, it is worth pointing out that the 'social model' of disability has itself been subjected to critique (Shakespeare, 2006; Harris, 2000). Critics complain that, just as the ICIDH may have overemphasised factors internal to the individual person to the neglect of social factors, in the causation of disability, the social model makes the opposite mistake; namely, by over-emphasising social factors and neglecting the significance of individual impairments. One might also add that it is difficult to see how the social model can easily encompass severe intellectual and sensory disabilities (French, 1993).

The international classification of functioning, disability and health

In response to criticisms of their earlier ICIDH, the WHO produced a subsequent version, which attempted to address some of the problems of the earlier one and used noticeably different terminology. The newer version is the *International Classification of Functioning, Disability and Health* (ICF) (WHO, 2001).

This new development should not be seen as a total rejection of the previous schema. One key similarity between the old and the new lies in its definitions of its three main categories. The old three-fold classification of impairment, disability and handicap is replaced with, impairment, activity limitations and participation restrictions. Previously, impairment (for example, an abnormality in anatomical structure, such as a missing spinal nerve) led to disability (inability to walk) and finally to handicap (such as an inability to work). The schema retains the part-whole-societal structure (WHO, 2001, p. 188), although the simplistic causal connection that some found in the ICIDH is now explicitly rejected in favour of a 'biopsychosocial' approach.

The three basic categories in the ICF are: 'Impairment is a loss or abnormality in body structure or physiological function (including mental functions). Abnormality here is used strictly to refer to a significant variation from established statistical norms (i.e., as a deviation from a standard population mean' (p. 190).

So, as was the case with the ICIDH, athletes with prostheses can be seen as impaired according to this definition for the same reason.

The disability dimension of the ICIDH, the 'person level' dimension, is defined thus:

Activity limitations are difficulties an individual may have in executing activities. An activity limitation may range from a slight to a severe deviation in terms of quality or quantity in executing the activity in a manner or to the extent that is expected of people without the health condition.

(WHO, 2001, p. 191)

The explicit reference to ‘activities within the range considered normal for a human being’ has been omitted here, yet there is a necessary appeal to some conception of normality against which limitations are to be understood: ‘Limitations or restrictions are assessed against a generally accepted population standard’ (p. 21). It is noteworthy that reduction in the quality of performance of an activity is mentioned explicitly within the definition. Thus, if a wheelchair athlete is capable of shooting an arrow in an archery contest, but, because of a condition which leads to muscular atrophy or loss of motor control (such as multiple sclerosis or cerebral palsy), can do this only seated from a wheelchair (as was the case with Neroli Fairhall in the 1972 Olympics), then one would also qualify as having an ‘activity limitation’. By way of summary, then, according to this new definition, the term ‘disability’ has been superseded by the term ‘activity limitation’. It is this term that is employed by the IPC in their literature (International Paralympic Committee, 2007), although its definition is stated more briefly than the WHO definition. According to the IPC, an ‘activity limitation’ refers to ‘difficulties an individual may have in executing activities’ (International Paralympic Committee, 2007). Thus, as mentioned earlier, one might hold that Mullins and Pistorius have an activity limitation, since, without their prostheses, both have difficulty walking as compared to a standard population.

The term ‘handicapped’ is no longer included in the ICF and is replaced by the term ‘participation restriction’, which is defined thus:

Participation restrictions are problems an individual may experience in involvement in life situations. The presence of a participation restriction is determined by comparing an individual’s participation to that which is expected of an individual without disability in that culture or society.

(WHO, 2001, p. 191)

So, as with the ICIDH category ‘handicap’, it appears that a ‘participation restriction’ is determined by reference to the kinds of activities typically engaged in by one’s standard peers, who become the reference class. If one is restricted from engaging in such activities, owing to ‘impairments’ or ‘activity limitations’, one is considered to suffer from a ‘participation restriction’. This opens the door to participation in Paralympic sport.

Building on the critics of the ‘medical model’, the authors of the ICF make it clear that disability should not be conceived of solely as a problem of or for individuals (that is, their anatomical structure and functioning). The role of environmental factors is explicitly acknowledged thus: ‘A person’s functioning and disability is conceived as a dynamic interaction between health conditions (diseases, disorders ...) and contextual factors’ (p. 10). To signal this, it is made explicit that the ICF involves a rejection of a medical model of disability, without embracing a social model. Instead, a model which recognises a role for both kinds of factors is adopted. As the ICF declares: ‘a “biopsychosocial” approach is used’ (p. 28) in this case. In other words, their approach – encapsulated in the definition – takes into account factors at each of the three-levels of analysis identified earlier. In summary, then, the new definition makes redundant the old terminology of impairment, disability and handicap.

Summary of the main differences between the ICF and the ICIDH

Although this chapter has thus far focused primarily on the WHO taxonomy of disability and its critics, it is important to signal the fact that disability is itself a hotly contested concept. An important alternative is proposed by Nordenfeldt (1983, 1993), who opposes simple biostatistical or positivistic understandings of both health and disability. Statistical norms play a key function in both WHO definitions and Boorse's philosophical theory. Nordenfeldt is critical of such biostatistically based approaches because they fail to do justice to the values and priorities of the individual person.

To illustrate this, consider the former multiple world and Paralympic champion wheelchair athlete, Dame Tanni Grey-Thompson (2001, p. 8), who has remarked, 'I do not think of myself as disabled'. Or, again, consider Pistorius, who, according to reports (Edwards, 2008), refuses to park in parking spaces reserved for disabled people because he does not consider himself disabled. Nordenfeldt's theory of disability lends some weight to their claims. His theory is that persons are disabled by virtue of their inability to *do* things that are important to them. Nordenfeldt labels these 'vital [personal] goals'. Thus, if leading a very active or athletic lifestyle is of paramount importance, to given individuals, and they are thus enabled (in addition to the activities of daily living), are able to fulfil their vital goals(s). Insofar as they are able to fulfil their goals, on Nordenfeldt's influential analysis, they would not be regarded as disabled. On this, more radical account, therefore, neither Mullins nor Pistorius (nor indeed wheelchair athletes) would be characterised as disabled.

According to Nordenfeldt (1983, 1993), *typically*, disabilities stem from a combination of internal factors (such as impairments) and external factors (such as wheelchair-unfriendly public transportation systems). The most striking aspect of this approach to disability is the emphasis on the views of the person concerned.

Time and space do not allow a full account of Nordenfeldt's approach but the description just given is sufficient to illustrate the central way in which it differs from the WHO approaches. Specifically, as indicated, it would certainly do justice to the kind of attitude voiced by Paralympic athletes and many others who would otherwise be classified as 'disabled' (by virtue of having impairment, plus an activity limitation, together with a participation restriction) according to the WHO definitions.¹

Wolbring (2008a) poses a further and more radical challenge to all attempts to impose classificatory schema on human beings based upon appeals to species-typical function. Such taxonomies manifest forms of what he terms 'Ableism: a favouritism for certain abilities that are projected as essential while at the same time labelling real or perceived deviation from or lack of these essential abilities as a diminished state of being' (2008a, p. 31). The suggestion here seems to be that any attempt to taxonomise humans in terms of what they are able to do manifests a prejudice against those who are believed either to lack those abilities completely or to display them to a limited degree only. In spite of this general concern about the privileging of certain kinds of abilities, however, it is obvious that some kind of classificatory schema is necessary in Paralympic sport in order for meaningful competitions to take place.

As noted above, according to the eligibility criteria of the IPC (International Paralympic Committee, 2007) clause 5.2 'an Athlete must have an impairment that leads to a permanent and verifiable activity limitation'. It is not obvious that all Paralympic athletes have an activity limitation, still less a permanent one. As is well documented, many Paralympic sprinters are capable of achieving highly respectable times in some track events by the standards of able-bodied national-level athletes. Compare, for example, the world records for the wheelchair marathon. While Wilson Kipsang of Kenya has covered the 26.2 miles in an incredible 2 hours,

3 minutes and 23 seconds, the Canadian wheelchair athlete Josh Cassidy has covered the same distance in 1 hour, 18 minutes and 24 seconds, almost twice as fast.

A critic might say that there would be ‘no contest’ between the two. This must, however, be understood in conceptual terms. While there exist sports contests where able-bodied and disabled athletes co-participate, such as archery or equestrianism, it is not obvious where co-participation ought to be permitted. In the case of the London marathon, for example, the wheelchair event is started before the able-bodied event, although they cover an identical course. Co-participation might, however, cause considerable difficulties, owing to the forms of motility between both sets of athletes. Clearly, the space occupied by a wheelchair athlete is considerably greater than that by a runner. But co-participation in the same event would beg questions as to whether the participants were indeed sharing the same test (Kretchmar, 1975). Moreover, calling on Suits’s (2005) notion of game playing, we can say that the wheelchair athlete is not using means permitted by the constitutive rules of athletics. In lay terms, it seems clear that the wheel chair athlete is rolling rather than running.

We can see that the WHO definition of activity limitations assumes that the activities referred to are unaided. Thus, it would indeed be the case that wheelchair and prosthetically assisted athletes are understood to have an activity limitation(s), where this refers to an activity such as ‘walking unaided’. Moreover, an important consideration for athletes with disabilities arises when considering the permanence of the activity limitation. Clause 5.4 of the IPC Classification Code states:

If an athlete has an activity limitation resulting from an impairment that is not permanent and/or does not limit the athlete’s ability to compete equitably in elite sport with athletes without impairment, the athlete should be considered ineligible to compete.

(International Paralympic Committee, 2007)

It is clear, then, that the permanence of the impairment is a necessary condition of an athlete’s proper entitlement to compete in Paralympic activities according to the ruling body, the IPC. How is the concept of permanence to be understood and applied? One could imagine that athletes might be regarded as ineligible to compete because of progress in medical or prosthetic technology. Equally, developments in genetic and nanomedicine raise the possibility of growing missing or repairing damaged tissues, which can be grown or transplanted (such as nerve tissue or bone). If this is the case, then many severe impairments will in fact not be permanent (that is, irremediable) because there is the possibility of remedies for the impairment arising in the future.

Finally, it may be interesting to consider the possibility of integrating Nordenfelt’s (1983, 1993) theory of disability with the IPC/WHO account of activity limitations. Recall that, according to Nordenfelt, one is disabled to the extent that one cannot, because of impairment, pursue one’s vital goals. If it is the case that many athletes competing in the Paralympics are indeed pursuing their vital goals perfectly satisfactorily as they themselves see it, then – perhaps paradoxically – it follows they should not be thought of as disabled according to Nordenfelt’s theory. Thus, the general impression that Paralympic sport is synonymous with disability sport would need to be abandoned. Instead, one would need to focus more on the notions of impairment and activity limitation, where the latter is understood to involve unaided activity. Indeed, it appears that this is the way that Paralympic organisations are heading (see also Howe and Jones, 2006, who anticipate the significance of a narrow focus on impairment and away from disability). Moreover, in addition to this potential to sever the conceptual link between

Paralympic sport and disability sport, some commentators think that the context of the Paralympics provide an ideal opportunity to develop the idea that human function can be enhanced by the use of technology. Running blades might come to be seen as very crude first steps along the journey to ‘transhumanism’ – that is an attempt to transcend the human biological form, and its constraints, completely via the use of increasingly sophisticated forms of biotechnology. Paralympic sport potentially provides the ideal vehicle for the transition from human, to cyborg (part human, part synthetic), to transhuman which some commentators envisage: some with apparent glee (see, for example, the website of the World Transhumanist Association) and some with dread (Wollbring, 2008b; Habermas, 2003).

Ethics and Paralympic sport

Unsurprisingly, ethical issues are plentiful in Paralympic sport, although they have not been discussed extensively within the philosophy of sport. We focus here on five ethical issues that are prominent in Paralympic sports. It is important to recognise that some of these are also issues in able-bodied sport (such as fair play and doping) but that there are also issues that are unique such as autonomic dysreflexia (or ‘boosting’ as it is commonly referred to) and elective amputation in order to gain eligibility to Paralympic sport or to enhance performance therein.

Equality, fair opportunity and fair play in Paralympic sport

All sports share the same ‘gratuitous logic’ in that they challenge athletes to overcome unnecessary obstacles (Suits, 2005). The overcoming of these difficulties or obstacles, which are created and preserved by the rules, is what gives sports their point and players their enjoyment. The underlying structure is that of a test which is shared by contestants in the form of a competition (Kretchmar, 1975). The rules that shape each sport are of two kinds: constitutive and regulative (Kant, 2007; Midgley, 1960; Searle, 1979). Constitutive rules define the activity (the size of the playing area; the duration of the activity; the composition and weight of playing equipment, and so on) while the regulative rules lay down what manner of means may be employed by contestants.

There is much dispute as to whether the rules alone create a structure of fairness within which contestants are able to engage in a mutual quest for victory (Simon, 1991) or whether rules are also necessarily reinforced by the ethos or prevailing set of unwritten norms as to how the activity should be engaged in (McFee, 2004). Clearly, both written and unwritten rules contribute to the fairness of the contest.

There are issues of equality that go beyond the nature of sports contest themselves. These relate to the treatment of individuals. Much has been made of the inequalities between Paralympic and Olympic sports. Athletes in Paralympic sport tend to be less well financially supported and rewarded, and enjoy less sports medicine and science support (Howe, 2009). Their media coverage, although it did improve for the Beijing Olympic Games of 2008, also falls far short of the Olympic Games, and this has immediate consequences for the funding of Paralympic sports and the profile of their participants. The 2012 London Paralympics included four sports (track and field athletics, rowing, swimming and table tennis) within the scheduling of the Olympic Games, which attests to the developing professionalism of Paralympic sport and recognition of the need to develop solidarity between the parallel games.

A further inequality that occurs outside of the Paralympic contest is found in the differences in access that Paralympians from varying countries to medical, sporting and technological resources. Take for example the case of severe spinal cord injured athletes who require the use

of catheters. Clearly, those athletes coming from developing countries need to use and reuse catheters for much longer than their wealthier counterparts increasingly significantly the risk (and in fact, incidence) of infections (Mills and Krassioukov, 2011). Equally, the Italian wheelchair athlete and former Formula 1 driver, Alessandro Zanetti, is reputed to use a hand-racing wheelchair made by Ferrari that cost €50,000, which would be an unthinkable sum for most wheelchair athletes. Its lightness and durability offer a clear advantage to Zanardi over his competitors.

It is an open question as to whether and to what extent Paralympic sport should model itself on, for example, Formula 1 motor racing, where there are relatively tight parameters on equipment specification. In many technology-dependent sports, policy makers will have to determine the parameters of equipment not merely on grounds of fairness but also in terms of harm minimisation (or prevention), and also to ensure that talent and training win out over mere technological advances afforded disproportionately to athletes from more privileged backgrounds. Clearly, as with all sports, it is both undesirable and practically impossible to make all background conditions equitable.

In terms of fair play and fair opportunity to win, it should be noted that the diversity of classifications for Paralympic contests is intended to ensure that like athletes compete against like athletes. This is not always possible, and the history of Paralympic sport is replete with such disputes. In this regard, it is worth mentioning the incident that led to the expulsion of intellectually disabled athletes. During the 2000 Paralympic Games in Sydney, Spain won gold in the basketball competition. It was subsequently found that 10 of the 12 players were not intellectually disabled.² Clearly, the possibilities for cheating – intentionally gaining an unfair advantage by means of deception – are more widespread in Paralympic sport for those with intellectual disabilities because it is harder to determine their classification in comparison to athletes with structural impairments. The basketball case in Sydney was the trigger for an in-depth evaluation of the eligibility system for athletes with a disability, which proved to be wanting. For this reason, the IPC took action against the whole class of athletes with intellectual disabilities by banning them from the Paralympic Games. This decision was recently overturned and athletes with disabilities competed in the London Games of 2012, although they will have to prove eligibility via a new ‘sports intelligence’ test (BBC, 2009).

A final example of fair opportunity to perform arises when Paralympic athletes and Olympic athletes co-compete. There have been many instances where athletes with a disability have competed on equal terms with Olympic athletes, although, in that context, they were simply viewed as athletes (DePauw, 1997). Notably, DePauw cites Liz Hartel (post-polio), who won a silver medal in the equestrian dressage at the 1952 Olympics, and Jeff Float, a deaf swimmer, who won a gold medal in swimming at the 1984 Los Angeles Games. Similarly, a wheelchair archer, Neroli Fairhall, also competed in the 1984 Olympic Games; however, her disability became an issue as her alleged stability advantage was questioned by traditional upright archers. If the fair opportunity to perform (Loland, 2009) is an important principle across all sports, then the stability of the base of the archer will be important to determine if a significant unfair advantage arises between contestants.

A more recent case occurred in professional golfing when Casey Martin won the right to play on the highly lucrative United States Professional Golf Association (USPGA) tour. Martin required the use of a buggy (motorised cart) to move between shots. The USPGA argued that because Martin did not have to undergo the same physical test as able-bodied golfers who have to walk the course, he would gain an unfair advantage over his competitors. The issue became the subject of a legal dispute. In 2001, the Supreme Court in the United States held, by seven votes to two, Casey’s legal right to use the golf cart in PGA tournaments. Ironically, he failed

to make the cut at the final qualifying tournament to determine eligibility to the professional US Tour.

Doping and therapeutic use exemption certification

As noted above, the rules of sport have a dual structure, Paralympic or otherwise, that have to do with whether they play a constitutive or regulative role in the relevant sport. It has also been argued that there are auxiliary rules (Meier, 1985), which are special regulative rules that determine how contestants may prepare themselves. Rules regarding the use of performance-enhancing methods and substances (colloquially referred to as ‘doping’) are examples of such auxiliary rules.

It is recognised in Paralympic and Olympic sport that the right to fair opportunity to perform in sport is subservient to the more basic right to health care. There arise in sports occasions where the need for medication for a medically authorised condition, which is also performance enhancing, supersedes competitors’ right to a fair contest. Contestants (or their medical support team) must ensure that there are no suitable alternatives that are not on the prohibited list of the World Anti-Doping Agency. They must apply for a therapeutic use exemption (TUE) certificate to legitimate their use of the banned substance or method. It is the athlete’s responsibility to ensure that the TUE is up to date and that, for example in the obtaining of new inhalers for asthmatics, that their contents or delivery systems for the medication do not offend the list which is regularly updated. This responsibility is in effect a duty of care: all athletes must undertake to train and present themselves in competition in a manner consistent with the rules of Paralympic sport.

The presence of cocaine on the list has long been controversial because it is not performance enhancing and the evidence base on its harmfulness has been questioned in relation to other recreational drugs such as alcohol which are not proscribed. Moreover, athletes must also be aware of the condition of strict liability. In doping cases, anti-doping agencies are not required to prove guilt or the intention to dope. The mere presence of a banned substance suffices to constitute a doping offence and subsequent suspension from participation (McNamee and Tarasti, 2010). Take, for example, the case of Canadian Wheelchair Paralympian, Jeff Adams, who won gold in the 2000 Paralympic Games. Adams was found to have committed a doping offence, and, despite his protestations that a stranger in a nightclub had put cocaine into his mouth and that he had ingested it unknowingly, was found guilty of an anti-doping rule violation.

Another class of activity that has occurred, may still occur but which is banned by the IPC is that of so-called ‘boosting’. In medical terms it is known as autonomic dysreflexia (Mills and Krassioukov, 2011) and it is claimed to be a form of self-harm. Boosting involves the athlete deliberately provoking a bodily response equivalent to an ‘adrenaline rush’, leading to increased heart rate and blood pressure. This may be done by a range of means, including self-administered electric shocks, intentionally withholding the release of urine or other forms of self-induced pain. The dangers are that, among other things, it can cause stroke or heart attack. In one sense, this looks categorically distinct from doping, since no extrinsic agents are used by the athlete, except in the case of electric shocks. Further, if a central function of classification in Paralympic sport is to reduce disadvantages that stem from the ‘natural lottery’, one might defend the practice by arguing that athletes with naturally low blood pressure are merely using their own bodies to compete on a par with those with naturally higher blood pressure. Alternatively, one could factor in the resting blood pressure of athletes in eligibility criteria and have two different events for the two categories of contestants.

Ethics, fairness and technology in Paralympic/Olympic sport

In the section on classification and eligibility above, the example of the South African runner, Oscar Pistorius, was used extensively. While he is far from alone in creating controversy in the history of Paralympic sport, his case provides an interesting and contemporaneous focal point for a consideration of whether and how technology may alter or even undermine the nature and goods (that is, those inherent aspects thought to be of value) of Paralympic contests and in his particular case, the possibility of shared competition between Olympic and Paralympic athletes (Burkett *et al.*, 2012; Edwards, 2008; Marcellini *et al.*, 2011; Wilson and Jones, 2009).

During the period prior to the 2008 Olympics in China, there was considerable debate over whether or not Pistorius should be allowed to compete, were he to make the required qualifying time for inclusion into the South African Olympic team. The main concern centred on whether or not his running 'blades' (prostheses) gave him not simply an advantage over other competitors but an unfair one. To substantiate or refute any such claim presupposes a robust definition of what counts as an unfair advantage, and that proved very difficult to produce. Moreover, although the debate took place in the context of consideration of his desire to compete in the Olympics, some cogent points can be raised in relation to his competing in the Paralympics too (for example, if it is true that the blades give him an unfair advantage in comparison to non-disabled runners, which excludes him from competition in the Olympics, perhaps it should follow that he should be ineligible to compete in the Paralympics too).

The kinds of advantages that the prosthetic blades were claimed to produce were mostly mechanical, attributable to the special properties of the blades. They are lighter than natural legs, more aerodynamic, and have reduced contact area with the ground when compared with natural legs. They may also give greater 'spring' than natural legs, thus leading to a longer stride. All these properties, it may be claimed, gave Pistorius an unfair advantage over athletes with natural legs (Jones and Wilson, 2009). It is somewhat ironic that Pistorius ended in second place to Alan Fonteles Cardoso Oliveira in the 400-metre event that he had been widely favoured to win. After losing, Pistorius remarked, 'If you look at videos from last year, Alan was shorter than me but now he's taller than me' (Paxinos 2012). A further irony here is that the reason Pistorius had employed shorter blades is because the Court of Arbitration for Sport had ruled that its judgment, allowing Pistorius to compete in the Olympic Games, was applicable *only* in relation to the specific blades tested. Clearly it would be impossible for an elite athlete to train with shorter blades for the Olympic Games and longer ones for the Paralympics, given the technical complexity of prosthetically assisted sprinting.

Even if one conceded that an advantage exists between and among competitors, one can still claim that it does not constitute an unfair advantage. (Nor, in the absence of rigorous evidence should we assume that Oliveira's longer prostheses gave him an unfair advantage). Suppose, for the sake of argument, then, that the blades do indeed confer an advantage. If this were so, would that be sufficient a ground upon which to exclude him? It is plain that advantages abound in sport. Current rules of competition do not exclude competitions in which some athletes have an advantage over others. For example, there are advantages that stem from the natural and social lotteries. These are not 'deserved', in that they are not earned. They are matters of historical accident. Thus, an athlete brought up in the high plains in Ethiopia might have an advantage over other athletes raised at sea level. An athlete raised in wealthy countries might be said to have an advantage over athletes raised in much poorer countries.

So some athletes are advantaged in relation to others because of factors over which they have no control. The arguments against allowing such advantages do not distinguish the kind of advantage (allegedly) possessed by one competitor from the advantages possessed by other

athletes regarded as unproblematic – such as those regarding athletes from the high plains of Africa, or wealthy countries. For, just as the ‘blades’ might not be available to other athletes, so being born and brought up in a wealthy country is not available to other athletes. And of course, strictly speaking, the blades could be available to other athletes, were they prepared to have their lower legs amputated.

Elective amputation

There might be at least two sets of reasons why Paralympic athletes might elect to have amputation surgery. First, it has been claimed by some persons that this or that limb does not feel a ‘part of them’. The idea of elective amputation is not a new one (Dyer, 2000). Generally, it is discussed in the medical and ethical literature under the guise of a body dysmorphic disorder (Eliot, 2003) or a body identity integrity disorder (Ryan, 2009; Müller, 2014). Such analyses identify an accepted disorder and subject it to a medical examination. Typically, there is no therapeutic indication to treat the limb as diseased. Rather, the elective surgery is better understood as a body modification, more precisely a ‘self-demand amputation’ (Sullivan, 2005). A second possibility is more problematic from the standpoint of regulatory bodies within disability and Paralympic sport. How should they view such a consideration? Moreover, it is not clear how clinicians should consider such an approach by athlete patients.

Two different approaches have been clinically identified that have application in disability sport generally and Paralympic sport in particular.³ The first pertains to the elective (non-clinically indicated) amputation of part of the lower legs of a wheelchair athlete in order to lose weight and thus enhance athletic performance. If one is impaired to X degree in context Y, does it necessarily matter that one elects to have greater impairment X+1 in order that one may enjoy superior wellbeing in contexts Y+1? (McNamee *et al.*, 2014). Is this just another performance-enhancing method like specialised nutrition or calorific control? A similar issue has arisen in the case of a former army veteran whose ankle joints were damaged by an improvised explosive device, who, post-surgery, could still walk but only with some discomfort. Having witnessed the magnificent feats of amputee sprinters, he sought elective double amputation to become a disability sprinter.

To what extent are these requests ethically justifiable? There is no theory neutral answer here. Clearly, along the lines of the medical model, these requested interventions look very similar to requests to facilitate self-harm (perhaps even mutilation). Along the lines of Nordenfeldt’s vital goals theory, it might appear that the athletes, post-successful amputation, might actually be flourishing. A further, political philosophical aspect is worth noting, too. If one assumes that the athletes are self-funded and that no one else is harmed, it can be argued that it is simply a matter of individual liberty that they be allowed to undertake elective amputation for such reasons as they (competently) see fit (McNamee *et al.*, 2014). In summary, however, one may distinguish the individual’s desire for such interventions, and their permissibility. Nevertheless, it does not follow that disability sports’ regulatory bodies should invite, condone or reject these persons from their competitions. It would be perfectly reasonable for them to deny access to such competitions on the grounds that their understanding of disability – whether congenital or acquired – need not include those who, in effect, create their own impairments.

Conclusion

In this essay, we have raised a number of conceptual and ethical issues that go to the heart of the idea of disability and Paralympic sports. The differences between different models of

disease, health, impairment and activity limitations are substantial, and we have not attempted to cover all of them. We have indicated some clear differences between what is called the medical model, and one, more subjective, alternative. It is clear that the WHO definitions, upon which the IPC rely, and others such as those devised by Nordenfelt (1983, 1993) are profoundly different? This illustrates the highly problematic nature of what might seem to be a straightforwardly clear concept, namely ‘disability’, and disability sports and Paralympic sport. We have also identified four issues that arise within disability and Paralympic sport: two that are merely modulated by the disability sport context and two that are *sui generis*. In discussing these cases, we have attempted to show how mainstream ideas from the philosophy of sport, together with the philosophy of medicine, bear upon disability and Paralympic sports for philosophers and policy makers alike.

Notes

- 1 The definition of disability and handicap given by Nordenfelt (1993, p. 22) is: ‘A disability, as well as a handicap, is a non-ability – given a specified set of circumstances – to realize one or more of one’s vital goals (or any of its necessary conditions)’.
- 2 Personal correspondence with a leading Paralympic scientist suggests that 60 per cent of the filed papers for athletes with intellectual disabilities were problematic. This suggests that the Spanish team was far from the only culprit here. Thanks to Prof Yves Van Landewyck.
- 3 With thanks to Dr Stuart Willick, who was indeed confronted by the requests that serve as examples in this section. A fuller discussion of these, and two further cases, can be found in McNamee *et al.* (2014).

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