

# Olympic Doping, Transparency, and the Therapeutic Exemption Process

Luke Cox

School of Sport and Exercise Sciences at Swansea University

*luke.cox1@aol.com*

Andrew Bloodworth

School of Sport and Exercise Sciences at Swansea University

*a.j.bloodworth@swansea.ac.uk*

Mike McNamee

School of Sport and Exercise Sciences at Swansea University

*m.j.mcnamee@swansea.ac.uk*

## Abstract

Within anti-doping policy, the Therapeutic Use Exemption policy enables athletes with a range of medical conditions to compete within elite sport even after receiving prohibited medication substances or methods. It has been claimed, however, that the policy is being misused as a means to enhancing performance in healthy athletes, or athletes who do not suffer from a relevant pathological condition. To counter misuse of TUEs, it has claimed that the data captured in the TUE process should be transparent, even though this would reveal medical information concerning the athlete that would normally be thought of as private. There are further concerns regarding the sharing of medical data within sports organisations, between medical professionals and performance directors or coaches. We critically explore the TUE process, and argue against proposals for a transparent TUE policy on grounds of privacy and concerns for athlete welfare. We conclude that the notion of sports integrity, the threat of doping, and the extension of anti-doping policy, need to be considered within a broader context that also concerns the goals of sports medicine and athlete welfare.

## Keywords

Doping, Ethics, Privacy, Transparency, Sports medicine, Data sharing.

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## Introduction

The threat of doping to Olympic integrity is increasingly evident. Recent Olympic games in Rio and London have been tarnished by claims of more systematic, organised doping influencing key results (Draper, Harris & Willison, 2017; WADA, 2016: 1). The pressure on anti-doping authorities, federations and governing bodies has led to some controversial policies that appear to threaten athlete privacy. For example there has been some concern over the World Anti-Doping Agency's (WADA) athlete whereabouts policy (WADA, 2015: 21:45), in which athletes in a registered testing pool are required to report and file their whereabouts for purposes of being available for a random drug tests. The requirement of athletes to be available for such out of competition tests for an hour a day, 365 days a year, has been the subject of much debate and challenge, on the grounds of whether this is a justified invasion of privacy or not (Hanstad and Loland, 2009; MacGregor, Griffith, Ruggiu & McNamee, 2013; Waddington, 2010).

Failing to comply with these whereabouts rules is one way in which athletes can commit an Anti-Doping Rule Violation. The WADA Code (2015: 18-23) stipulates a range of further doping offences, beyond those that concern the use of prohibited substances and/or methods. These include - but are not limited to - evading the providing of a sample, refusing to do so, and prohibited association, where for an example an athlete works with a coach who is serving some form of ban for a doping related offence.

Anti-doping policy comprises many purposes, not limited to catching cheats. In order to enable athletes suffering from a health condition to receive the treatment to which they are entitled, the Therapeutic Use Exemption (TUE) policy has been developed. This is particularly concerned with allowing athletes controlled access to substances on the prohibited list where good medical practice requires this. Disaffection and even distrust of the TUE policy (Overbye & Wagner, 2013), has arisen because some athletes consider this process can undermine the fairness of competition. Furthermore, the unethical hack of the WADA's website by the Russian group known as Fancy Bears, revealed the medical records, including records of the TUE Certificates granted to number of athletes. It is fair to say that there were raised eyebrows and the names of certain athletes who had received TUEs and the substances for which they were granted. Moreover,

the informed reader could make inferences, or educated guesses, as to the pathologies the athletes reported suffered from. One of the most high profile of the TUE grantees was Sir Bradley Wiggins the multi Olympic gold medal winning UK cyclist. These illicit disclosures fuelled media reports and negative public perceptions of the TUE policy (Fancybear, 2016). Prior to considering this environment of mistrust in greater detail, and potential solutions to it, we first describe the policy in some detail.

### **Anti-doping policy, sports medicine and TUEs**

The WADA (2016: 10) states, an athlete may be granted a TUE if (and only if) he/she can show, by a balance of probability, that each of the following conditions is met:

- a) The Prohibited Substance or Prohibited Method in question is needed to treat an acute or chronic medical condition, such that the Athlete would experience a significant impairment to health if the Prohibited Substance or Prohibited Method were to be withheld.
- b) The Therapeutic Use of the Prohibited Substance or Prohibited Method is highly unlikely to produce any additional enhancement of performance beyond what might be anticipated by a return to the Athlete's normal state of health following the treatment of the acute or chronic medical condition.
- c) There is no reasonable Therapeutic alternative to the Use of the Prohibited Substance or Prohibited Method.
- d) The necessity for the Use of the Prohibited Substance or Prohibited Method is not a consequence, wholly or in part, of the prior Use (without a TUE) of a substance or method which was prohibited at the time of such Use (WADA, 2016: 10).

If approved, the TUE Certificate results in an athlete having controlled access to a banned substance or method found on the WADA's Prohibited List. The Prohibited List asserts those substances that are prohibited either in or out of competition, or both, and in which sports. Application of the TUE policy treads a very fine line. For a substance to be placed on the WADA's Prohibited List, it must meet two of three criteria. 1) Enhances performance or has the potential to do so; 2) Detrimental to health or potentially so; 3) Contrary to the Spirit of Sport (WADA, 2015: 30). While some recreational drugs such as marijuana

seem to be on the Prohibited List (WADA, 2017: 7) because they meet the health and spirit of sport criteria, many substances are banned because of their enhancing effects, in combination with their potential for harms to health. Thus many TUEs concern the legitimated administration of a banned substance in a controlled fashion with the immediate purpose of restoring health rather than enhancing performance. Restoration, however, can only take place if the pathological condition causing a detriment in health and performance has been properly diagnosed. Contrary to these legitimate purposes, if the detriment to performance has been over estimated, or the condition itself should not have been diagnosed, the prohibited substance may lead to significant enhancement rather than mere restoration.

The WADA produce TUE physician guidelines on medical information to support, guide and assist the decisions of TUE committees on a range of medical conditions. For example, the WADA provide guidelines on asthma, a condition many Olympic athletes, notably endurance athletes, biathletes, and swimmers, appear to suffer from. The information outlined within this document presents the following: 1) defines the medical condition; 2) demonstrates diagnosis criteria, highlighting the medical history an asthma sufferer would typically demonstrate; 3) the examination and tests to be carried out by medical teams or doctors when diagnosing a medical condition; 4) medical treatment, the substance, route, frequency, duration, alternative treatments and consequences if the treatment is withheld from the athlete (WADA, 2015: 1-12). For those medical treatments that are potentially permitted for an athlete's use, some of these treatments can be found on the WADA's Prohibited List. This is the case for asthma and Glucocorticoids.

### **TUE certificates, exploitation, and mistrust**

We noted above how the Russian computer hacking team, Fancy Bears, gained access to the WADA's TUE medical records and released the medical information of a number of athletes, including those of Sir Bradley Wiggins (Fancybears, 2016). Wiggins, it must be stated, did not incur any Anti Doping Rule Violation (ADRV), but the legitimacy of the granting of his TUE has been subjected to intense media scrutiny. Wiggins was later challenged in a UK governmental enquiry about the TUEs he was granted during his career. His medical history revealed the use

of a corticosteroid, used to combat asthma and allergies, before three Grand Tour races, including the 2012 Tour which he won (DCMS, 2017). Due to the suspicion and mistrust caused by Fancy Bears, questions began to surface that queried the legitimacy of the TUE process, hinting at possible exploitation of the TUE policy in order to enhance performance, rather than merely to treat existing ailments.

Accordingly, on 19 December 2016, the UK House of Commons, and the Department for Digital, Culture, Media & Sport, moved to conduct a public debate on the use/abuse of the TUE policy and wider doping issues. The Culture, Media and Sport Committee held evidence sessions with Team Sky, British Cycling and the WADA, as an inquiry into combatting doping in sport. Collins (2016) makes the important point, especially given the high levels of public funding for sports (and especially cycling), 'that it is important that sports follow the letter and spirit of the anti-doping code. We want to understand more about the ethics of the use of TUE's and the way Team Sky and British Cycling police the anti-doping rules'.

In response to this interview, on 17 April 2017, a Team Sky whistleblower submitted an anonymous email which included the following:

Under the current rules I do not think that there has been a breach, however, I do believe that TUE's were used tactically by the team to support the health of a rider with an ultimate aim of supporting performance. At that time there were regular rider review meetings and all details of the rider were discussed medical confidentiality was wavered (this is common practice in sport) and the seriousness of Brad's (Bradley Wiggins) allergies were not discussed. The use of the Triamcinolone acetonide was never discussed in these meetings however it had been discussed out side of the rider review meetings as a general discussion because it had been used for years in cycling and the consensus was it would be in appropriate to use. In 2012 the team was under extreme pressure to perform, Dave Brailsford and Shane Sutton put a great deal of pressure on the medical team in particular Richard Freeman to provide more proactive medical support. Using TUE's was openly discussed in hushed voices as a means of supporting health and wellbeing (DCMS, 2017).

The first line of the whistleblower's narrative is somewhat ambiguous. An ethically justifiable use of TUE policy would be to use it to support the health of athletes, and one might reasonably conclude that this will eventually support performance outcomes as an indirect consequence. Their use of the term "tactically" suggests, however, something beyond the mere treatment of illness. Although the validity of the whistleblower's statement is difficult to assess, the perception arose that medical processes including the TUE process were being used for performance gain at least raises questions over the manner in which this is being accomplished.

Some of the whistleblowers comments hint at the potential conflicts of interest that sports medicine professionals might have. At what point ought their concerns extend to performance, and indeed the improvement of performance, rather than just the maintenance or restoration of good health? Might these two goals be in conflict at times? These conflicts of interest are also identified within research conducted by Overbye & Wagner (2013).

They argue that roles of a GP (general practitioner) or sports/team doctor when involved in the diagnosing of the possible medical condition of an athlete while at the same time being under the influence of commercial and/or political interests, represents a conflict of interests. This points to a potential grey zone between therapeutic use and doping. Although the TUE policy offers athletes with legitimate medical conditions a chance to return to normal function, the subsequent treatment provided to an athlete can also be exploited to gain an athletic advantage over fellow competitors. Overbye and Wagner (2013) also report on athlete perceptions that the TUE process is being exploited for performance gain, rather than merely for the restoration of health.

Further evidence of the potential exploitation of the TUE policy is exactly what is demonstrated within *The secret race*, a 'kiss and tell' book authored by Daniel Coyle and Tyler Hamilton. It describes how Hamilton, a professional road race cyclist and former teammate of Lance Armstrong, engaged in doping practices, including the exploitation of the TUE policy. Within the book he claims:

Another way to hide was through the use of TUE's-therapeutic use exemptions, which were mostly used for cortisone. The UCI permits riders to use certain substances with a doctor's prescription. So the team doctors would invent some phantom problem-a bad knee, a saddle sore-

and write a note allowing you to use cortisone or some similar substance. The only trick to it was remembering what made-up ailment the doctor had given you-was is your right knee that was supposed to be injured, or your left knee? Before races, I'd sometimes check the paperwork to make sure I knew which knee to complain about if the tester happened to ask (Coyle & Hamilton, 2012; 176).

Although the credibility of such sources can always be questioned, this evidence suggests exploitation of the TUE policy exists. The extent of this practice, and its significance in terms of affecting the results of competitions is of course, like the doping problem itself, difficult to establish. Nevertheless there are concerns that abuse of the process represents an opportunity to dope with the unwitting acquiescence of anti-doping authorities. We will now discuss the moves currently being considered in sport and anti-doping policy to combat such threats.

### **Privacy, confidentiality and the extension of anti-doping policy**

In response to perceptions and suggestions of improper practice a number of recommendations have been made in the media, and from those working in sports organisations, and from athletes or former athletes in an attempt combat the exploitation of the TUE policy (Brailsford, 2016; Zhukov, 2016; Adams, 2016; Boardman, 2016). In the case of British Cycling, arguments have suggested that those in authority such as performance directors, ought to be aware of what riders are being treated with (Cooke, 2016).

The first recommendation to be discussed and reviewed concerns increasing transparency within the TUE policy. But what do we really mean when transparency is considered? By 'Transparent' is understood that which is clear and easy to understand, open, honest and without secrets (Cambridge, 2017). Accordingly, when the transparency TUE policy is discussed, it implies that every detail about the TUE process was in the public domain. This would mean that an athlete's medical data, medical conditions and the medical substance use to treat that condition, would be public knowledge. Only then could one properly label the TUE policy as 'transparent'.

Team Sky cycling manager, Sir Dave Brailsford, has suggested that the TUE policy should be made more transparent to improve compliance, and combat potential exploitation. Brailsford (2016) states:



On one hand you've got the people who would like to know what is going on against the contrast of medical confidentiality,' (...) 'I think in there is a balance. We've reviewed this over the years and we've changed our policy, we've changed the way we do it and going forward I think we are going to take the next step which is being debated on a wider basis to look at, with the consent of the riders, making all TUEs transparent. You ask yourself the question: if a rider needs a TUE you can either make it public so everyone knows they have a TUE, or they don't compete (Brailsford, 2016).

One possible justification for this shift towards transparency stems from the supposition that transparency would render doping via TUE processes much more difficult to exploit. For example, shifting towards a more transparent TUE process would mean a greater number of individuals would have access to each TUE case. This would in turn facilitate greater public scrutiny and accountability of TUE applications and approvals. If athletes and their doctors perceive the TUE process to be under greater scrutiny, they may be less likely to seek to exploit it. Increasing transparency might also better demonstrate the good work that such a policy does, raising awareness that athletes sometimes have serious medical conditions that require medical treatment—even where products used may be on the prohibited list. Finally, increasing transparency would ensure that the individuals involved within the process of granting a TUE certificate, remain compliant with the relevant TUE processes. In summary, calls for a shift towards a more transparent TUE policy have clear benefits and are likely to gain momentum.

Nevertheless the increased transparency proposal does not come without its own challenges. Arguably, a shift towards a more transparent TUE policy could present a new range of ethical issues for anti-doping policy makers to consider. The WADA (2016) states,

It is a fundamental human right that personal medical information be kept confidential.

Nobody would want such information disclosed, let alone for it to be debated publicly.

Athletes should not be required to publish their TUE information, which may de facto disclose their disease or



condition, nor should they be required to publicly defend their legitimate use of a TUE.

Evidently the WADA are against proposals to move in the direction of a more transparent TUE policy, and the foundations of their argument appear focused on a notion of privacy. Accordingly, we will now discuss the concept of privacy in relation to a more transparent TUE policy.

The concept of privacy is far from straightforward (MacGregor, 2013). It has been called it a “cluster concept” (DeCew, 1997). She identifies three-forms (i) informational privacy; (ii) accessibility privacy and (iii) expressive privacy. Clearly the former is of greater relevance in terms of the TUE policy. The intuitive question to ask is “who may legitimately know what about me?” In this vein, the medical ethicists Beauchamp and Childress (2013) define ‘privacy’ as a state or condition of limited access to information, which involves the agent’s right to control that access. Clearly we can foresee many, perhaps most, athletes saying that their medical conditions and treatment records are a matter of private concern. And this of course is widely supported in medical ethics, law and professionalism.

Suppose a shift towards a more transparent TUE policy was made. It is plausible to suggest that athletes’ medical records and diseases would be exposed. As athletes would have little, or no control over who might have access to this personal information, athletes’ privacy would be jeopardised. Moreover, it could be argued that particular medical conditions could be more sensitive than others. Trying to determine which of these conditions, if any, might justifiably be made public, would represent an insuperable conceptual and ethical challenge. If sensitive medical conditions were exposed under a prospect of increased transparency, it is possible that this would create athletes’ additional unwarranted harms, which could include athlete drop out, marginalisation, humiliation and loss of revenue. Due to the serious nature of these threats, a notion of increasing transparency within the TUE policy becomes less ethically justifiable.

Moreover, the details about an athletes’ medical condition or illness may be so sensitive that they wish not to disclose this information with loved ones, let alone the general public. Evidently, this presents challenges when a more transparent TUE policy is considered. Allen (2016) writes,

Some people do not share the knowledge of medical symptoms even with their closest friends and family members. Reluctance to share knowledge of medical symptoms with associates or kin and medical professionals may stem from fear of disability or death; avoidance of discrimination in insurance, employment and education; or dread of social stigma, shame, embarrassment or rejection.

A further argument against creating a more transparent TUE policy concerns the competition itself, and the potential for transparency to alter the way in which athletes compete within sport. Suppose a shift towards a more transparent TUE policy was made. Opposing athletes could develop games plans or strategies that target the athletic vulnerabilities caused by the medical condition. This is exactly what Pete Sampras, the tennis player, did not want to happen throughout his career. Chan (2013) writes, 'his medical condition was a closely guarded secret. It was not until he retired from competitive tennis, that Sampras admitted that he has thalassaemia minor. He is quoted to have said that he did not want to give his opponents a psychological advantage'. Evidently, by shifting towards a more transparent TUE policy, athletes would have little say over these matters regarding medical privacy. Due to the potential influence that transparency has on Olympic medalists, it would appear that once again, a shift towards a more transparent TUE policy appears questionable.

One might of course, seek to bypass these ethical problems by suggesting that the consent of the athlete would be paramount, and so where athletes give consent they have waived any right to privacy. Certainly, some athletes may want to make such data public, in order to demonstrate their own integrity, as well as preserve the integrity of the sport. The difficulty here, however, is establishing the quality or validity of the consent secured. Doping is such a significant and emotive issue in sport, that the pressure on athletes to demonstrate their cleanliness – a concept that is far from easy to operationalise – is already burdensome. If it becomes the policy of a governing body, or team, or indeed a sporting nation, to require that their Olympic athletes were required to disclose details of the TUEs, it would certainly be difficult for an athlete to resist this trend, and not to authorise such data sharing. Yet if the pressures to do so are coercive, after all there are only so many Olympic games one may qualify for, then it seems forced to call this 'consent' – since that requires the element of voluntariness. If the choice to disclose

normally private medical records cannot be thought of as free from coercion, we find this move unjustifiable due to the unwarranted pressure put on athletes in this difficult position.

When arguments for and against a more transparent TUE policy are considered, it appears that transparency could reduce the potential for exploitation of the current TUE policy. Nonetheless, we have identified a range of ethical issues which challenge transparency as a guiding principle of the TUE process. Ultimately we consider athlete privacy to override broader concerns around abuse of the TUE process. Alternatives exist: subtle shifts in team, federation and national Olympic committee policy, such as separating sports medicine departments from those departments more concerned with scientific performance objectives; developing strategies to reduce the potential conflicts of interest that arise for sports medicine professionals who are drawn into such performance concerns. These both might be useful ways of guarding against TUE exploitation. Neither bring with them harm to important ethical values such as privacy and confidentiality. We also contend that claims that athletes could freely consent to such data sharing are questionable given the elevated context in which anti-doping policy operates.

### **Transparency, data-sharing and sports medicine ethics**

The UK government's Department for Digital, Culture, Media & Sport Review raised further questions as to the knowledge and oversight performance directors and coaches have of medical decisions for inter alia the Sky cycling team, who are almost co-terminous with the Team GB Olympic cycling team. Former Gold winning Beijing Olympic medalist, Nicole Cooke in her evidence to the inquiry questions argued that those in charge of teams, such as Team Sky, ought to be aware of what medical substances their riders are treated with. Cooke (2016) also claimed that remarks by the then Head of Performance, Shane Sutton, to the effect that he had not been involved with the TUE process for Wiggins, did not 'ring true' with her general experiences. This raises an important question concerning the proper disclosure of medical details, in order to better support anti-doping policy. Precisely who ought to have access to such data beyond the athlete and the anti doping authorities?

A related issue concerning the disclosure of information pertaining to athletes that dope is already enshrined as an ADRV in anti-doping policy. The doping offence of complicity concerns 'Assisting, encouraging, aiding, abetting, conspiring, covering up or any other type of intentional complicity involving an anti-doping rule violation' (WADA, 2015). The intention here is to deter athletes from associating with known doping athletes or scientists and physicians (collectively referred to as Athlete Support Personnel) who have been charged with an ADRV. The attraction of such a clause is clear, particularly when authorities might think some form of systematic, organised doping is being undertaken. The clause, however, does offer some challenges to sports medicine professionals who might uncover doping. If an athlete they are working with discloses their doping activities it is unclear whether they are primarily bound by duties of confidentiality of their national medical association, or whether the WADA Code supersedes such considerations and requires breaking of confidentiality by disclosure to anti-doping authorities? McNamee & Phillips (2009), have raised this difficult issue for anti-doping policy, and the sports medicine professional. In subsequent versions of the Code, the problem has not been addressed. At its heart the problem concerns the function and primacy of responsibilities of sports medicine professionals, in the context of potentially conflicting duties: those to the athlete (to respect their desire not to disclose doping) and those to anti-doping authorities (to protect sports integrity). A further argument might also be made in favour of disclosure that hinges around the athlete welfare (or welfare of other athletes). This is not entirely straightforward, however, because the athlete might claim that their welfare would be more significantly damaged by failing to respect their wishes for the information to remain confidential. Or they might simply claim, in accordance with the principle of respect for autonomy, that they are best placed to decide what is in their best interests.

Similar concerns arise in the context of data-sharing more generally. Should medical information be freely accessible, beyond the healthcare team, to coaches or performance directors? In a recently released UK government report on the duty of care owed to athletes Baroness Tanni Grey-Thompson discusses data sharing, and suggests in a medical context National Governing Bodies need not have preferred access to 'non-acute, non-relevant data'. (2017: 25). A case might be made to the effect that while a

condition such as asthma might affect the training and coaching of an individual, the precise or particular medication that individual might not meet those criteria and ought not to be disclosed to those involved the training or competitive support. Much will depend on how the terms “acute” and “relevant” are interpreted. This issue goes to the heart of our first problem concerning the *complicity* clause and doping. If sports medicine professionals perceive an obligation to disclose the facts concerning a doping athlete, this appears to compromise their duty of care to that athlete. And indeed might such a breach of confidentiality, since the athlete will not want to inform others of their breaking the doping rules, also breach the sports medicine professional’s own stringent professional ethical codes? One recommendation from the report states ‘Consideration should be given to the separation of medical services within a sport’s performance department to give a clear line of demarcation to ensure that medical advice cannot be compromised.’ (2017: 25). This separation of functions might help better define which data is relevant to each individual or group, and why this might be the case.

One potential response to this problem is to ask athletes to consent to specific data sharing in advance. In doing so, athletes would waive their rights to confidentiality in this and other instances, but only within established parameters. In her Duty of Care Report, Baroness Thompson remarks upon contracts that waive rights to confidentiality, suggesting that they be scrutinised on legal grounds. In ethical terms further questions arise. Again, further consideration must be given to the quality of consent secured? Athletes might agree to sign contracts entail a broad consent that waived rights of confidentiality in the future, for unspecified acts. This broad consent (Sheehan, 2011) is widely discouraged in the context of research ethics for example, with some exceptions in big data and biobanking research (Thompson and McNamee, 2017). Why then would it be acceptable in anti doping policy? A critical ethical and legal debate is necessary, however, concerning the grounds of whether the athlete can really be aware of the importance of what they are waiving before athletes, teams, national federations, or Olympic Committees go further down this route. After all, at the time of signing, no one is aware of just how the contract might be used to bypass issues of confidentiality. The problem of TUEs illustrates the myriad of duties and responsibilities faced by sports medicine professionals. While

in our first example performance concerns are suggested as potentially conflicting with medical care of the athlete, the ultimate clash of principles in deciding whether a transparent TUE policy is justifiable concern the integrity of sports competitions themselves, as set against the limits of the privacy of individual athletes. The second example, concerning WADA's complicity clause, and data sharing more generally, raises a similar dilemma: might we justify compromising medical confidentiality in order to better detect doping, or abuses of anti-doping policy and support fair competition. While it can be claimed that the disclosure, or breach of confidentiality, would be for the benefits of the doping athlete him or herself - a paternalistic one to protect them from harms to health - there are some strong ethical objections to this. The use of the doping substance might not itself comprise a very significant harm to health, over and above the risks an elite athlete encounters on a regular basis as part of sporting competition or training. Even where the risks are significant, we might encourage a policy that involves counselling of individuals, rather than one that potentially alienates athletes and discourages them from seeking medical help. Arguably, contracts that waive rights to confidentiality may make it less likely that doping athletes access reliable medical care, and counselling as to the risks they are undertaking. Yet the argument for disclosure is a familiar one. Fair and just competition protects all athletes, and the sports in which they partake (Loland, 2002). We might all need to suffer significant inconveniences, as in the case of random drug testing for example, in order to preserve sporting integrity. In the context of the problems under discussion, having policies that encourage sports medicine professionals to breach confidentiality, either via the publishing of therapeutic use exemptions, or informing on an athlete breaking the rules, can be seen as being in the interests of fair competition, and thus all athletes.

The contention here, however, is that such claims offer a dubious extension of anti-doping policy. The current context of anti-doping calls into question whether athletes can consent to such waivers independent of coercion. Policy changes that bypass athlete autonomy, while claiming to preserve sports integrity offer too narrow a conception of integrity. Sports integrity should not just concern catching doping cheats, or match fixers, but requires a proper understanding of those values, such as autonomy, confidentiality and privacy, essential to athlete welfare.

One ought not to conclude from this that concerns for the protection of autonomy (under the aspect of informed consent) always outweigh concerns around preserving the fairness of sport. There may be more minor contraventions of autonomy that might be justified in such terms. Nevertheless, we argue that anti-doping policy requires proper attention to athlete welfare, and that a transparent TUE policy, or waivers of confidentiality, is more likely to undermine it.

Finally, but importantly, we also contend that such policies do not get to the core of the key ethical issue here. The conflicts of interest that some might argue are inherent in the role of the sports medicine professional (see Edwards and McNamee, 2006) require addressing and resolving, rather than seek to address the problem further down the line, via restrictions on athlete autonomy. In line with this we offer support recommendations by Baroness Thompson regarding a clear separation between sports medicine departments and performance enhancement concerns, including as the report goes on to discuss, consideration as to the management such departments fall under.

## **Conclusion**

The threat of doping to major sporting events, and to sports integrity generally is clear, with recent scandals further threatening the ideals of fair sport. Here we have offered a critical discussion of the alleged reform of anti-doping policy. While the TUE policy may not be without its faults, we support the continued inclusion of the TUE policy and its provisions for confidentiality within the WADC. We object to a transparent TUE policy citing privacy and confidentiality concerns as having primacy. Likewise, in the context of data sharing, either concerning doping athletes, or just concerning the medical details of athletes, we urge a proper consideration of the reason to share data in this respect, and whether it ultimately sufficiently respects the autonomy and welfare concerns of the athlete. Athlete welfare concerns, it is argued, ought not be separated, or glossed over, in the formation of an ethically justified anti-doping policy. Our analysis suggests that in the instances we discuss at least, there is a danger that anti-doping policy has hitherto paid inadequate attention to such concerns.



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## **Authors**

**Luke Cox** is a PhD student in the Applied Sports Technology Exercise and Medicine (A-STEM) Research Centre within the School of Sport and Exercise Sciences at Swansea University. He recently completed a Master of Science by Research, whereby he executed an ethical and conceptual analysis of the Therapeutic Use Exemption policy.

**Andrew Bloodworth** is a Senior Lecturer in the School of Sport and Exercise Sciences, Swansea University. His teaching and research is in the field of sports ethics, more specifically the ethics of anti-doping policy. Andrew is also Chair of the College Research Ethics Committee.

**Mike McNamee** is Professor of Applied Ethics at Swansea University, UK. He is Program Chair of the Erasmus Mundus Joint Master Degree in Sport Ethics and Integrity (MAiSI). A former President of the International Association of the Philosophy of Sport, he has published widely in the ethics of sports.

