**'What to do with the TUE process? Bradley Wiggins, Therapeutic Use and Data sharing; a critical analysis'**

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**The Therapeutic Use Exemption (TUE) Process is an important but controversial aspect of anti-doping policy. Athletes' medical conditions may in some cases require treatment involving substances or methods on the World Anti-Doping Agency's Prohibited List (PL). A TUE may be granted where certain criteria are fulfilled, and the relevant anti-doping authorities deem this a medical necessity that will not compromise the integrity of sporting competition. We discuss, first, a number of foundational questions regarding the implementation of TUEs and challenges to the existence of the policy itself. We go on to defend a TUE policy with minimal modifications in terms of fairness and justice, but with a more transparent and detailed rationale. Secondly, we critically evaluate recent policy decourse regarding its openness to exploitation of the policy and how this might be reduced. We reject calls for complete transparency on the grounds of the privacy of athletes healthcare data and support an approach to anti-doping policy that is more attentive to the needs and indeed autonomy of individual athletes.**

## Introduction; The Therapeutic Use Exemption Process in Anti-Doping Policy

The majority of anti-doping scholarship has focused on the rationale for such a policy itself, and the problems arising from the consideration of substances and methods for the Prohibited List . More recently, the Therapeutic Use Exemption process (commonly referred to as the TUE process) is an aspect of anti-doping policy that has come under recent scrutiny. This scrutiny was heightened after Russian hackers 'Fancy Bears' managed to hack and disclose some of the World Anti-Doping Agency's (WADA's) records of top athletes and the therapeutic use exemptions they had been granted (Fancy Bears, 2016). The data published by the Russian hacking organization, Fancy Bears, and in particular the details of Bradley Wiggins' Therapeutic Use Exemptions also formed part of a UK Parliamentary Inquiry into Combatting Doping in Sport. (Digital, Culture, Media and Sport Committee, 2018). This chapter will offer an ethical analysis of the problems arising from the application of the TUE process. This includes a discussion of proposals to (i) abolish the TUE process altogether; (ii) and making the details of athletes' TUE applications and awards more widely (even publicly) available, as a way of discouraging exploitation or dishonest use of the process.

The WADA (2015: a) TUE policy allows an athlete with a medical condition (that meets the criteria outlined below) to receive controlled access to a substance on the prohibited list (see WADA, 2018). Based on WADA's criteria (stated below) a substance may only be permitted for

an athletes' use on the basis that it will merely restore normal function for that athlete, rather than offer an enhancement to performance. Below are WADA's criteria for obtaining a TUE:

> 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, 2016b: 10).

Athletes are in principle entitled to the appropriate treatment of acute or chronic medical conditions, even if such a treatment requires the use of a substance on the Prohibited List. Use of such a substance, however, must be "highly unlikely" to result in an additional enhancement beyond restoration of the athlete's normal function.

A complex anti-doping policy instrument such as this raises a number of questions. At root the policy offers a distinction between therapy (or treatment) and enhancement. Challenges to this distinction bring into question not only the TUE policy, but also the entire anti-doping effort.[1] The literature within the philosophy of medicine attests to the fact that is also notoriously difficult to define health, and what constitutes a significant impairment to health (Boorse, 2011; Nordenfelt, 2001; Schramme, 2007) in an indisputable way. Certainly, the TUE policy inherits some of these difficulties and differences that may prove harmonising the policy a challenge. Moreover, the qualification that the drug be 'highly unlikely' to produce additional enhancement has raised questions in the literature pertaining to vagueness (Pike, 2018). Previous versions of the policy (WADA, 2011) more straightforwardly stipulated that no additional enhancement to the athlete receiving a TUE was permissible. The introduction of the term "highly unlikely", however, can be understood of a recognition that the practice of medicine and medical science cannot grant assurance that therapies would be categorically non-enhancing. The clause "highly unlikely" might therefore create a space where athletes proper access to medications while preventing reasonably foreseeable exploitation while avoiding an anti-doping rule violation.

[1] A discussion of this is beyond the scope of this paper. See: Morgan, (2009); Daniels, (2000).

One possible line of argument is to focus not on the policy itself, as the origin of ethical and practical difficulties, but on the exploitation of the process by dishonest athletes and athlete support personnel. The full extent of TUE exploitation is unclear. The scholarly and journalistic literature suggests athletes perceive that the system is being exploited (Overbye and Wagner, 2013) and presents some first-person confessions of such practices (Coyle and Hamilton, 2012). Analagous to the problem of ascertaining valid estimates of the prevalence of doping itself,[2] the actual extent to which TUE exploitation is a widespread problem is unclear. By "exploitation of the policy" we refer to the approved access to otherwise prohibited medications via the TUE process in an attempt to gain an advantage over competitors, rather than merely to restore their normal function. It is thought that athletes could, by manipulating the extend of an existing condition, or even fabricating such a condition altogether, gain access to medication (or an enhanced dosage) in an undeserved manner that may prove beneficial to them in performance terms. Such abuse should, it could be argued, be prevented or detected by a stringent administration of the process itself (for further details of the process, and how it is handled see The International Standard for Therapeutic Use Exemptions (WADA, 2015: b). The practice of medicine, however, relies not only on scientific data, but on the reporting of symptoms by the patient, and treatment will of course follow in part on the basis of this reporting of conditions whose causes are uncertain or disputed (as in the case of all "syndromes"). This inescapable feature of medical practice may well offer scope for exploitation.

A tale of (Triamcinolone acetonide and) two Sirs.

The accusation of TUE exploitation has been levelled at cyclist Sir Bradley Wiggins in recent UK Parliamentary committee hearings. It should be noted that Sir Bradly is Britain's most decorated Olympian. The details of Wiggins' TUE use, which he later commented upon publicly (Gibson, 2016), were illegally revealed as part of the Fancy Bears hack of WADA's database. There, and in subsequent discussions and media reports, it became clear that Wiggins was granted a therapeutic use exemption certificate for the administration of glucocorticoids prior to three major races. Wiggins did not commit any anti-doping rule violation in obtaining controlled access to these drugs, which he used for the prevention of hay-fever induced asthma (Armstrong, 1996). The anti-doping authorities were aware of this condition and had approved its use. Controversy, however, followed the disclosure. Some cyclists and indeed some scientific evidence suggested that the substance for which Wiggins was treated had an enhancing effect (Raul, Cirimele, Ludes & Kintz, 2004; Duclos, 2010). It should be noted that the validity of these claims is not without challenge. If evidence were indeed compelling for an effect of this nature, the TUE for the drug should not have been granted. Granting the TUE suggests that the enhancing question is at the very least contested, and that due process has not been challenged by commentators, we may conclude that those granting the TUE thought additional enhancement was "highly unlikely".

Nevertheless, the timing of the TUEs, and the nature of the drug, has led some to suggest that this has been to the very significant reputational loss for both Wiggins' and Team Sky's much vaunted reputation for "clean" success. The situation for Team Sky, and for its head Sir David Brailsford worsened during a Digital, Culture, Media and Sport Committee (UK Government) review into doping in sport (DCMS, 2016), including the use of the TUE process. During the inquiry a number

[2] For a recent review on the prevalence of doping, and some of the problems in conducting research of this nature see; de Hon, Kuipers and van Bottenburg, (2015).

of those involved failed to identify precisely the contents of a so-called "mystery package", delivered to Wiggins for another race in 2011. This package was the subject of a subsequently dropped UK Anti-Doping inquiry. Subsequently, Team Sky disclosed that the package contained the decongestant Flumicil, which is not on the Prohibited List. This disclosure became the subject of considerable debate note least because of the delay in identifying the medication, but the inadequacy or incompleteness of medical records pertaining to the Fumicil disclosure and other treatments to Team Sky riders. Members of the Committee queried why Brailsford was unaware of the details of his athlete's medical records given the historical cycnicism around doping cynicism in elite cycling and the much publicised clean approach of Team Sky. Neverthleess, Brailsfor maintained that he was not privy to the details of Wiggins' medical treatment (DCMS, 2016). Members of the committee seemed unhappy with this response. Quite whether Brailsford's defence concerning medical confidentiality is as weak as suggested by some will be the subject of discussion below.

The Parliamentary Enquiry reported its findings in the early part of 2018. Practices at Team Sky came under significant criticism for a number of issues (i) the apparent exploitation of apparent grey areas, for example the use of medications not on WADA's prohibited list (such as tramadol or out-of-competition corticoid use) for their alleged enhancing effects; (ii) the poor keeping of medical records; and (iii) their lack of support for a subsequent UK Anti-Doping enquiry. Somewhat surprisingly, the Enquiry also inferred that Wiggins did seek to exploit the TUE process for performance gain. For this conclusion to be properly founded, however, it would depend on access to Wiggins' medical records and an understanding of his intention neither of which is presented in their report. Wiggins continues to deny vehemently that he sought to exploit the TUE process in this fashion.

**Should we abandon the TUE process altogether?**

The foundational question concerning the TUE process is whether it should exist at all. In light of the significant risk of exploitation does its presence compromise anti-doping efforts? Dimeo and Møller (2017) argue that it is time to scrap the TUE system altogether. It is notable, however, that despite their strong line, the very last few sentences of their article suggest room for a slightly softer stance, suggesting that WADA explore ways to soften this blow for those in genuine need. Their argument in favour of scrapping the TUE process comes in three parts: 1) the potential for exploitation of the system; 2) the lack of consistency in administration of the process; and 3) that scrapping the system would be both in the short-term and long-term interests of athlete's welfare. Our view aligns to some extent with the reasons offered here, and the need to address them. But, we argue, these reasons do not sufficiently support the abolishment of the TUE policy: effectively, their cure is worse than the condition it seeks to ameliorate.

First, we consider their account of the potential exploitation of the TUE policy. Dimeo and Møller offer some evidence of either perceived exploitation of the process, or suggest that the culture of elite sport is such that unscrupulous athletes will use it to try and obtain some form of advantage. There ought to be no denying this possibility. Inventing a condition to obtain a prohibited substance would be following neither the spirit nor letter of the law so to speak. Rather, it would be merely a deception in order to dope. But Dimeo and Møller might refer here to an example of an athlete seeking the most powerful drug that might reasonably be thought of as a treatment for a

condition, and the highest dose of it, to try and gain some benefit that extends beyond the restorative. This is obviously problematic, were it to occur, and the suggestions are that this is occurring, and athletes are gaining an unfair advantage over their competitors. The process is being used as a way of making further marginal performance gains. Dimeo and Møller suggest that cycling coach Shane Sutton has said as much in a recent television programme (BBC, 2017). The Guardian newspaper reports the dialogue from the BBC programme:

> "If you've got an athlete that's 95% ready and that little 5% niggle or injury that's troubling them, if you can get the TUE to get them to 100%, of course you would in them days.
> "The business you're in is to give you the edge on your opponent and ultimately it's about killing them off but you definitely don't cross the line and that's something we've never done."
> [Asked if] "finding the gains might mean getting the TUE", [Sutton repeated the question, before adding:]
> "Yes, because the rules allow you to do that." (Fotheringham , 2017)

First, we should note a relevant ambiguity in Sutton's comments. Sutton may be interpreted as referring to marginal gains supported by a restoration of health rather than using the TUE process to extend performance beyond normal function (enhancement). Indeed, this is the more generous interpretation. The potential for the TUE process to lead to enhancement is a serious issue. Pike (2018) argues persuasively, that healthcare professionals are unable to for see all the effects of taking a medication on the PL, intended and unintended, and make concrete conclusions regarding the potential for enhancement. This would require the professional to be confident that in each individual, who may well react in different ways to a substance (as we have seen in the discussion of Chris Froome's recent Adverse Analytical Finding), the effects of the drug can be more or less precisely predicted in terms of ensuring restoration only, and any secondary effects prevented (Wynn, 2018). Expecting this degree of precision from current medical knowledge seems unreasonable. Indeed Pike (2017) suggests that WADA should loosen their criteria to allow for moderate enhancement, a move that he argues is more reflective of the current state of play. Importantly though, Pike does not suggest that this loosening is a threat to the TUE process altogether.

Pike offers an original application of the doctrine (or Principle) of double effect to anti-doping. Reserved commonly for discussions of healthcare professionals, the distinction is often used to support or decry the hastening of a dying patient's death or indeed abortive practices. Its justification splits philosophers and bioethicists equally (cf Kamm 1999; McMahon 1994) Roughly put, defenders focus on the original intention in pursuit of ethically valuable ends, while detractors focus on the negative foreseeable consequences. In the context of the present discussion the salient difference between athletes using medications should not be understood in terms of the complex effects of the medications themselves, but in terms of the intentions behind the use of such medications (Pike, 2018

). This negates the assumption that the abuse of the TUE process is the primary goal of the athlete (or their support system). Dimeo and Møller are nevertheless concerned with those who intend to cheat, and the possibility of the TUE process to provide a useful vehicle for achieving this without detection, or indeed with the approval of the anti-doping authorities. Pike's work is ultimately

critical of WADA's current lack of interest in the intentionality of athletes, at least in this process, to determine whether an anti-doping rule has been committed. We do not engage with the difficult issue as to how best to incorporate intention into anti-doping policy here. We do note, however, that the use of strict liability elsewhere in the prosecution of ADRVs means at least that their approach is consistent. Moreover, it would add a layer of complexity and finance to attempt to revise the regulatory framework and processes to a degree where a panel could be "comfortably satisfied" of the athlete or their doctors intentions, or even come to such a decision on the "balance of probabilities" – a stronger jurisprudential conclusion.

Our recommendations with regard to the TUE policy, and in particular with regard to concerns as to its exploitation raised above echose Pike's own defence of the process. We should retain the policy, although we would not object to an adjustment of the language employed to more adequately reflect the ambiguities at play here.. In short, we shall argue for the importance of the TUE policy as a just policy that protects athletes' welfare and livelihoods' where they might suffer from a genuine, potentially chronic medical condition. We argue for the policy despite the potential for enhancement and indeed exploitation that might exist. It is the lesser of two evils so to speak.

First, in support of this argument, grant a basic point. From the fact hat a rule can be exploited we cannot conclude automatically that there is something wrong with the rule itself. Diving ("simulation" in FIFA-speak)in football has a number of similarities to the exploitation of the TUE process. It involves deception, in order to seem as if one is playing by the rules, while in fact the attempt is for an illegitimate advantage. We might argue over whether the foul in football is a rule more central to the sport than the anti-doping rules and TUE process. But we might also suggest that the response to diving should be the same as the response to the TUE process. Target more directly those in the wrong who are trying to cheat, rather than change rules or policy.

Secondly, we acknowledge, that there is potential for enhancement inherent in the TUE process. This is not the place (neither are we the people!) to conduct a review of the science. Medicine may not currently possess the precision required to limit the effects of the medication to the purely restorative, or to limit the secondary effects that impact upon performance. We still argue that fairness dictates athletes where necessary have access to substances on the prohibited list for medical treatment. Loland develops an idea of fairness in sport based upon 'Equality of opportunity to perform' or the Fair Opportunity Principle (FOP). The crux of Loland's Fair Opportunity Principle is as follows:

> *we should eliminate or compensate for essential inequalities between persons that cannot be controlled or influenced by individuals in any significant way and for which individuals cannot be deemed responsible*. (Loland, 2010: 118).

Essential inequalities are understood as inequalities with a significant influence on sporting performance. Assuring athletes fair opportunities to perform does not just require adequate classification to moderate the effects of differences like size, weight, or financial inequalities. It requires that athletes unlucky enough to suffer from a medical condition have an opportunity for compensation in the form of appropriate medical treatment. Athletes with medical conditions cannot simply, via training, compensate for the effects of these conditions. Where the condition is unlikely to impact upon training or performance the TUE should not be granted. But where there

is likely significant impact upon performance, this also concerns the potential for significant disruption to athletes' careers and livelihoods, or indeed prevention of some individuals from taking up the sport at an elite level altogether. Justice may in some instances not require equality, but the differing treatment of those in differing need. Some athletes are unequal in respect of suffering from a medical condition that impacts upon their sporting participation, justice requires that anti-doping policy may be applied *mutatis mutandis*. Where an athlete genuinely requires access to medications, even those on the PL, they ought to have access to them to the degree relevant to their medically relevant circumstances.

A further point, raised by implication should be considered. One can only wonder what implications there might be for Paralympic sport were Dimeo and Møller's proposals taken on board more generally. What, for example, would a consistent position be on those who require various treatments and devices in order to compete in the first place? Any policy based, at least in part, on compensatory justice is likely to create problems of line drawing. Our position is a principled one: we uphold the primacy of athletes' right to healthcare and medical treatment over their prohibition from competition on grounds of unmerited medical conditions.

Attempts to classify athletes in this fairness-promoting way in sport cannot reply upon exact sciences. Good and wise judgment is the best we may hope for, and that is likely to generate exceptions and even some unpalatable conclusions. Likewise the TUE process, limited as it is by the application of current medical knowledge cannot guarantee an entirely level playing field. This issue of perceived unfairness that the TUE can give rise to, however, is not as significant as that which would result in preventing the competing of those on the grounds of a medical condition, or at least preventing them receiving standard medical treatment for the condition and competing.

A defence of the process in terms of justice does not of course remove the potential for exploitation. Indeed our analysis, in acknowledging potential indirect enhancing effects, leaves this as a distinct possibility. Our suggestion here would be to challenge the ethics of those involved, athletes and indeed athlete support personnel, rather than seek to remove a process that can support those with a genuine medical condition to continue in their occupation. If problematic norms exist that would normalise exploitation then it is the norms be addressed, rather than policy further shift to reflect these ethically problematic behaviours. This is of course easier said than done. One solution should be the development of auditing to deter abuses, either by athletes of "rogue" doctors. Athlete profiles could be monitored in a manner analagous to the current use of Athletes' Biological Passports or the so called steroid profile. this view would be consistent with the medically conservative one that exploitation of the TUE process involves the *misuse* of medical means, properly understood as aimed at the relief of suffering and restoration of function (Edwards and McNamee, 2006). A separation of performance and medical functions, organisationally and in terms of their respective aims might discourage those otherwise inclined to pressure or utilise medical professionals in the pursuit of competitive advantage. This separation might be further strengthened where the fate of coaching staff, if results are poor for example, is not in anyway tied to the fate or job security of medical teams or departments.

Second, Dimeo and Møller cite an inconsistency in application and indeed understanding of the process. Again, we are in agreement with many of the points here. The first appears to suggest that the process creates an injustice, whereby those with certain injuries must rest, but those with

conditions that might respond to certain treatment do not, and can seek rectification via the TUE process. This, we hold, is an inescapable inequality in sport, some injuries respond better to different forms of treatment. The key part of the process is to ensure approval of the appropriate treatment, even if this involves a banned substance. The following points, however, raise some concerns central to the practice of elite sport in general. First, it is argued that those with privileged knowledge and access will be more likely to use the process, and thus compete, while others without such knowledge may be unable to perform or return to play. Indeed, Loland (2010) has indicated his own concerns with uneven access to sports science systems support in general. Here we might say, in agreement with Dimeo and Møller, that there is plenty of work to be done in educating relevant athletic (and media) populations concerning anti-doping policy, viz. the TUE policy, and its challenges. But the aim here should be to democratise access to sports science support and sports medicine support more generally. That way sport can test the athletes' hard work and natural ability, not their access to sports science support or knowledge of the intricacies of anti-doping policy. This might of course sound a somewhat idealistic line. Essentially, we reject policy changes that promote or strengthen the currently inequitable distribution of sports science and sports medicine support. Instead we support Loland's view of sport that seeks to democratise such access, while retaining a policy that is essentially in the interests of sick athletes. Our argument would be to continue with a rigorous anti-doping education, in order to better inform athletes of the appropriate processes should they be ill or injured, and possibly require prohibited substances.

Dimeo and Møller also express concern that some athletes, hindered by their own ethical sensibility, will be less likely to use the process, and thus places themselves at a disadvantage. This seems a pertinent concern. We might think of students in a university, and the reticence of some to use the extenuating circumstances system to gain a deadline extension, despite good reason, as a comparator. Again, we might question whether the solution should be the abolition of the process. Instead, as we suggest above, perhaps through increased education, we could facilitate proper use of the process. It is, after all, there for those that *need* it. They *need* medical treatment in order to compete at normal function, and the appropriate medical treatment is a banned substance. Students and athletes might choose not to use the process, either autonomously electing to suffer the disadvantage, or because they are not sure that their condition really affects their performance so significantly.

Dimeo and Møller's final abolitionist argument is a paternalistic one concerning the potentially damaging effects on athletes' long-term and short-term health. Athletes would, they suggest, be better off resting than competing having received the treatments that the TUE process allows. Are some interventions concerned with the restoring of the health of athletes, or have they extended to be more concerned with getting the athlete back competing regardless as to whether this in the athlete's longer term or shorter term best interests? The latter is an conceptual inflation of medicine beyond its traditional aims of restoration, and into the realm enhancement, sporting, goals (Edwards and McNamee, 2006). The aim should be to attain the *treatment* that best reflects the autonomous desires of the athletes themselves. They might be willing to accept some risk in order to compete, or, in adopting a more holistic less physical conception of health, claim that competing would actually be in their best interests both in terms of health and more broadly. Ensuring the athlete's decision is a free one, without coercion, requires careful consideration of the elite sport environment, and the context in which such decisions are made.

Sociologists Malcolm and Waddington (Waddington and Roderick 2002; Malcolm and Scott, 2013: Malcolm 2016; Waddington, Scott-Bell and Malcolm, 2017) have produced extensive literature depicting elite sport environments in which medical confidentiality is not protected, can be affected by the conflicts of interests that medical professionals in these contexts face, and have questioned the nature and quality of the consent players might offer for the sharing of medical data. While our concerns here do not concern confidentiality and medical data directly they are relevant. To what extent is athlete autonomy being respected with regard to the TUE process? Are athletes able to offer their informed consent to treatments without interference perceived or otherwise from performance focused staff? The research of Malcolm and Waddington in this football and rugby depicts an environment less attentive to these important issues of consent and autonomy, and more concerned with the ease of sharing information in the interests of the team or club as a whole.

Athletes seeking medical advice must be assured that their medical data will only be shared with their informed and considered permission. This should assure that their confidentiality is respected. This is an important step in ensuring that the decision to race, or to use medical treatment including a TUE in order to do so, is the athlete's own, made after careful contemplation of the risks involved. Organisations such as governing bodies and teams must be cognisant of the way in which team goals, and the longer term best interests of the athlete in terms of health may differ. Structures and functions, such as separation of medicine and performance functions would help to ensure that where risks to health, or some impact upon longer term health is accepted, as is fairly commonplace in elite sport, this is a result of the informed judgement of the athlete, not the pressures of the environment within which they work. As an aside it should also be stated that the aim of the process is to rectify significant impairments to health, and also allows athletes suffering from chronic conditions to continue to compete, not just the often discussed response to an acute ailment.

In short, our defence of the TUE process in response to the criticisms of Dimeo and Møller concerns the relationship between the arguments offered and the conclusion. We acknowledge a problematic ethos within some sections of elite sport, and the implications of this for a process such as the TUE policy. We argue that while many of the reasons hold, a more optimistic view of the possible culture of elite sport, rather than an acceptance of current norms, makes room for changes that address these practices, rather than rule changes. In the following sections, we seek to explore one possible way of addressing and reducing the possible exploitation of the TUE process.

**Enhancing the therapeutic use exemption process: confidentiality, transparency and medical data sharing**

Having tentatively defended WADAs TUE process as it stands we move to consider ways of enhancing it via exploitation-reducing measures. The controversy over Bradley Wiggins' TUEs are a useful start point with which to consider potential solutions. Our concern, however, is a more general one. As we have noted Team Sky's Sir David Brailsford has been criticised for not being fully aware of the medications or treatments that his riders were receiving. Having endured such criticism it is perhaps unsurprising that Brailsford has proposed an entirely transparent TUE process (Butler, 2016), in which data concerning medications are shared not only within teams and

performance staff, but also to the public. This may have some sort of advantage in terms of restoring trust in the process itself. Elsewhere, however, we have argued against an essentially public TUE process, suggesting that this is an indefensible invasion of athlete's privacy (Cox, Bloodworth and McNamee, 2017). Waddington, Scott-Bell and Malcolm (2017) demonstrate that a weaker version of transparency is already in existence in some form. In this form data is shared freely within teams, between medical and performance staff. This should not be necessarily seen as a transgression of patient confidentiality, where effective medical treatment is indeed a team affair (McNamee, 2014). This might help ensure proper oversight and adherence to anti-doping policy. The advantages are clear. Those in a position such as Brailsford's, ultimately accountable we might argue, will be able to retain oversight over medications, and ensure due process.

Before raising some concerns some conceptual ground needs charting. In using the concept of "privacy" we are referring to a state or condition of limited access to a specified thing (Beauchamp and Childress, 2013) under the discretion of the individual seeking to protected that access (Solove, 2005). In medical interactions, we might expect certain information to remain completely private (not to be disclosed further) and some only to be disclosed in a manner in line with the professional relationship with which both the doctor and patient are engaged. A breach of confidentiality would concern information being disclosed in a fashion that deviates from this typical interaction, in a manner in which I, the patient have not consented to.

Pike (2018) has argued in favour of a public TUE policy, and indeed one in which the athletic community are involved in the decision making process over whether they are granted. Here we have been predominantly focused on a defence of the policy itself. An ethical analysis of a transparent TUE policy is the topic for another paper. At this stage though we note two important reservations. First, objections might be made purely in terms of the importance of respecting autonomy of athletes' decision maing, and related to this, respecting of their privacy. In the current anti-doping climate it might be difficult for athletes to decline to release their data in this way, without looking like they're trying to hide something. A process that itself requires the release of data, rather than being an athlete choice, raises serious questions as to the balance between supporting anti-doping efforts and pressures on athletes to accept privacy invasions not expected in other occupations. The hacking of WADA's databases should serve as a warning here.

Secondly, even if advocates of a transparent TUE process are not persuaded by appeals to autonomy and privacy of this nature, the overall consequences of such an approach may compromise the justice that the policy seeks to promote. Pete Sampras was said to guard his medical conditions exceptionally closely so that his opponents could not exploit them. A similar point may be made of any athlete whose injury status might be exploited – quite legitimately – by opponents. Under some conceptions of transparent therapeutic data process to access otherwise prohibited medications, athletes may coerced into disclosing conditions that unfairly render them at a competitive disadvantage.

## Conclusion

Our primary focus has been the defence of the TUE process as it stands. We acknowledge potential for exploitation and enhancement inherent in the process but offer some tentative proposals for

addressing an ethos that accepts exploitation, rather than doing away with a valuable policy. Fairness, as we have argued is an important goal in sport. Following Loland, (2002) we have argued that enabling access to medical treatments under conditions of necessity and with highly unlikely enhancing effects, seems the least worst policy on offer. It affords athletes rights to healthcare while retaining (some) oversight of zealous or permissive athletes, sports medicine and science support team. These rights extend to those concerning the proper access to what are considered private medical data. We have expressed concern that the proper goals of sports medicine appears to be under pressures of conceptual inflation (Edwards and McNamee, 2006), from the therapeutic to enhancement goals. Conflicts of interest arise at the close intersection of sports medicine goals and those concerned with performance. The exploitation of the TUE process is an example of these distorted ways in which some view sports medicine.[3] Separating the functions of medicine and performance within teams and organisations, rather than increasing the transparency of the TUE process, may in the longer term be a better way of demonstrating the separateness of the process from performance and enhancement aims.

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[3] We should note here that recent empirical interviews and questionnaires with sports medicine professionals have suggested a group wholly attentive to their responsibilities to patients first and foremost. So our comment is not intended as a report on the values of the profession generally.

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