advocates the privatisation of public information that would by analogy revolutionise privacy laws by way of intellectual property.

The Review also puts forward the proposal of establishing a European tax to support grass roots funding.[74] It will be recalled that although the Community has the competence to extract external tariffs and to harmonise certain aspects of taxation with impact on the internal market, the imposition of a novel Community-level sporting tax is unlikely to meet with legal or political approval. Also, the form in which some of the 'guidance' requested by the ISR could be legally binding is not beyond dispute. If sport is regulated by European authorities acting within the Treaty framework such as the proposed European Sports Agency, it could be empowered to issue guidelines not unlike Commission comfort letters and notices in the field of competition law that, although not legally binding, are respected by enforcement and supervisory powers. Whether such a move would withstand constitutional scrutiny is a matter for more detailed study than that offered by the Review or this paper. In any case, both the delimitation proposed and any alternative solution would require adjudication from time to time as to whether particular rules fell within permitted categories. In this respect, either the proposed European Sports Agency or any other extrajudicial body would be exercising such functions analogous to public law powers under the Treaty that it ought to be open to judicial scrutiny in the event that it manifestly abuses those powers. Therefore, the proposal merely adds an intermediate tier to the pre-existing legal system at the pinnacle of which the European Court of Justice is firmly perched. In relation to legal instruments for particular reforms, some of these raise again the paradox underlying the 'specificity of sport' justification in the context of the Review. If sport is within the Treaty in so far as it satisfies other legal bases for regulation, it would constitute economic activity under internal market rules that is a necessary precondition of positive harmonisation under Articles 94 and 95 that serves to eliminate internal market failures. On the other hand, if it is a purely sporting consideration, the Treaty system could allow for cases where this justifies exemption or disapplication of rules for economic, social or other legitimate public policy reasons but not harmonising measures or positive integration based on the non-existent sporting competence. For example, positive harmonisation in the form of a hard legal instrument of a European system of player transfer regulations would require acceptance of the fact that it pertains to a generally economic activity and therefore a facet of the internal market and within all applicable internal market Treaty rules. The Report can not without selective interpretation both locate sport outside the internal market and on the other hand justify broad legal measures for the Treaty purposes of 'directly affect[ing] the establishment or functioning of the common market'[75] or the 'object [of] the establishment and functioning of the internal market'.[76] In particular, some propositions as to the legal bases of proposed measures[77] raise questions of competence. For example, there is considerable academic literature on the limits enunciated in the case law of the ECJ on the circumstances where Article 308, proposed as the basis of the European Sports Agency, might be considered an appropriate Treaty legal basis.

In conclusion, the ISR presents a great number of proposals for legislative and regulatory innovation relevant to sport. On the whole, it seems that the impact of some of its legally feasible proposals could benefit from a more robust analysis of their economic and social consequences, with particular emphasis on determining whether other fields of economic activity display similar characteristics and therefore require similarly tailored rules. Conversely, the report puts forward a number of innovations that seem incompatible with the current Treaty irrespective of the legal methods proposed within the Review. The 'specificity of sport' thesis, although initially limited to particular aspects with established precedent gradually develops into an instrument of less discriminate effects, bludgeoning rather than piercing the current legal dilemmas in European sports regulation. Nevertheless, the report catalogues well the totality of sporting-specific rules and offers a number of interesting proposals that merit further analysis to an extent difficult in the context of a remit as broad and ambitious as to 'reconcile the competing interests and priorities of sport within this [legal] framework'.[78]

74 IESRev, p. 85
75 Article 94 EC
76 Article 95 EC. See for example *Tobacco Advertising* Case C-376/98, *Swedish Match* C-210/03 and *Alliance for Natural Health* C-154 and 155/04.
77 IESRev table of measures, pp. 116-118.
78 IESRev, p. 9.

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Doping, Doctors and Athletes: The Evolving Legal Paradigm

by **John O'Leary and Rodney Wood***

In the past, legal interest in anti-doping violations has tended to concentrate on the relationship between The World Anti-Doping Agency (WADA), the governing body and the athlete. In the limited examples of an athlete bringing a successful legal action in response to a governing body sanction, the focal point of legal debate has often been a technical one, such as the effectiveness of the chain of custody or the adequacy of testing procedures. Effectively, the aim has been to seek legal redress as the result of a failure on the part of a governing body.

The Balco Enquiry and the repercussions of the ATP positive tests due to contaminated supplements[1] hint however at the potential for a shift in the traditional legal focus. In both instances, at least part of the focus was on the culpability of those providing the banned substances. Could these examples indicate a potential change in legal emphasis away from the governing body/athlete nexus toward the relationship between the athlete and the medical practitioner? Is this is so, what are likely to become the prevailing legal issues?

The object of this article is to explore the relationships that exist in the area of anti-doping and health. Its aim is to map out the tensions, obligations and responsibilities that exist between the actors and identify the possible focal points for future legal conflict

The Development of Anti-Doping Policy and the importance of good health

There is little doubt that doping has been around for as long as professional sport. However the crude use of stimulants that gave questionable benefits to our ancestors bears little relation to the sophisticated doping techniques allegedly employed by athletes today. Houlihan correctly identifies that the 1980's "watershed" in anti-doping policy was due, to a large extent, to "the recognition by govern-

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1 Charlish, P, I.S.L.R. 2005, 1(Feb),19-22.

ments and sports organisations that doping was a much more intractable and complex problem than they had at first thought".[2] One aspect of this prognosis was that sport was perceived as lagging behind the "dirty chemist" who, by the constant introduction of new drugs and techniques, could ensure that either scientific testing could not detect substances or that the banned list of substances in the rules of governing bodies were never contemporaneous.

Sport's response to what has been referred to rather emotively as "the war on doping" was the formation of the WADA. Wada's response was the development of a document aimed at tackling the perceived problem of doping in sport. The World Anti-Doping Code was launched in Copenhagen in 2003. In its preamble the code describes itself as

> "the fundamental and universal document upon which the World Anti-Doping Program in sport is based. The purpose of the Code is to advance the anti-doping effort through universal harmonization of core anti-doping elements. It is intended to be specific enough to achieve complete harmonization on issues where uniformity is required, yet general enough in other areas to permit flexibility on how agreed upon anti-doping principles are implemented".

The Code goes on to establish to criteria that underpin the need for such a document:

- To protect the Athletes' fundamental right to participate in doping-free sport and thus promote health, fairness and equality for Athletes worldwide and
- To ensure harmonized, coordinated and effective anti-doping programs at the international and national level with regard to detection, deterrence and prevention of doping

These criteria require further analysis. In the first criterion it appears that the athlete's fundamental rights promote health, fairness and equality. It is hard to reconcile the concepts of fairness and equality - indeed the notion of equality in sport might be seen as wholly undesirable and unfair. The idea of good health as an aspiration however, seems laudable in this context. The idea that the health of the athlete as a central tenet of the code is further reinforced by the criteria prescribed for a substance to be included on the banned list. Article 4.3.1.2 states that a substance might be included on the list of banned substances if "Medical or other scientific evidence, pharmacological effect, or experience that the Use of the substance or method represents an actual or potential health risk to the Athlete".

This promotion of health is to be achieved by the implementation of the second criteria: the detection, deterrence and prevention of doping. The word "detection" is clearly understandable and further documentation from WADA prescribes how anti-doping agencies and laboratories might achieve this objective. The notions of deterrence and prevention however are more nebulous. Are deterrence and prevention to be achieved by punishment or education? Although education does feature in the code, the majority of its provisions are aimed at establishing culpability and imposing punishment. Equally the prescriptive language used in the articles aimed at establishing an offence and punishment are not reflected in the article on education. Article 18 appears to impose little in the way of compunction on a governing body to provide education. If doping in sport is such an axiomatically terrible thing then a good programme of education should significantly reduce the number of "offenders" (and thereby protect their health).

The Athlete/Governing Body Nexus

If an effective anti-doping code is predicated on the collective confidence of the various stakeholders, then in order for the WADA code to work effectively, bearing in mind what some might consider "draconian" provisions of strict liability[3] and sanctions[4], there needs to be a belief on the part of athletes that anti-doping is objective, transparent and effective: in essence, that there is an appropriate social contract above and beyond any legal rights that the parties may claim. Little has been written on the concerns of athletes in this context: this may be as a result of the difficulty establishing a dialogue with competitors but could also represent the inherent suspicion of revealing opinions of an anti-doping system that athletes feel would be contrary to the prevailing anti-doping philosophy. One survey of elite-level fencers elicited responses such as

> "The Diane Modahl case didn't make me feel confident about the procedure. There were a lot of questions unanswered about her case: the levels of security over her sample - you can't say for certain that it was her sample. Until you can be confident that the sample you give is properly looked after and the system is foolproof, people will always be sceptical. It's not necessarily the testers' fault but there are so many hands through which samples pass. I think corruption is rife in sport. There have been cases of tampering with samples and I think swapping a negative sample for a positive one could conceivably happen".[5]

And an elite level disabled athlete has claimed

> "My greatest fears regarding adulteration of products comes from the health foods market, as I tend to use alternative health food remedies to prevent colds ... [the Drugs Helpline at the Sports Council] would not even tell me if vitamin C in an unadulterated form was a legal permissible substance. I can understand that the Governing body does not want to create a situation in which they could be found liable for any advice given on these unlicensed products. However their advice that I took such products as a simple vitamin c tablet "at my own risk" was to me taking the fear of potential legal action too far. The official's statement that these products could contain other substances not listed was correct, but to not be able to tell me if an unadulterated product was legal or not appears to me to set severe limits on the ability of the body to fulfil its function."[6]

If there is the perception that support networks, drug testing procedures, chain of evidence and rules of evidence are uncertain, athletes will only respect and have confidence in the rules and thereby the underlying philosophy of the drug-testing movement if the systems in place satisfy athletes by being not only foolproof but transparent. As Lord Hewart so rightly stated "It is not merely of some importance but is of fundamental importance that justice should not only be done, but should manifestly and undoubtedly be seen to be done."[7]

The Athlete/Doctor Nexus

Athletes who perceive their governing body as unsupportive or lacking empathy with their aspirations are likely to move away from the quasi-familial nexus that they may have enjoyed or that they perceived as having existed previously with their governing body and form closer bonds of trust with family, coaches and doctors whom they see as supportive and encouraging to them as individuals. This migration of loyalty paradigm is not unique and this "metamorphic process"[8] been noted in other areas of sport where individual athletes are beginning to feel a greater affinity with actors such as agents who they identify as being more closely attuned to the aspirations of the individual athlete.

If this is so, then athletes are forced to rely upon experts and sources of information that are not directly linked to sport or their governing body. As result of the sophisticated nature of doping tech-

2 Houlihan, B, The World Anti-Doping Agency: Prospects for Success in O'Leary, J (ed), *Drugs and Doping in Sport* (2000), London: Cavendish, 128.
3 Article 2 of the WADA Code.
4 Sanctions on individuals are dealt with in Article 10.
5 McArdle D. "Say it ain't so, Mo." 7 International performers' perceptions of performance-enhancing drug use and the Diane Modahl affair. (2001) *Drugs and Doping in Sport* O'Leary J.(ed.) Cavendish, London.
6 Curtis A. "Drugs in Sport: An Athlete's View". ibid.
7 v Sussex Justices (1924) KB 259.
8 O'Leary J and Caiger A "The Regulation of Football and its Impact on Employment Contracts" p.333 in *Legal Regulation of the Employment Relation* (Collin H, Davies P and Rideout R ed.) Klewer, London.

niques, it is likely that they would need to consult a doctor. Indeed, that doctor might reasonably be the person prepared to prescribe a banned substance. Although in the first instance the advice sought might be entirely legitimate, for example, advice on substances that would not fall foul of the anti-doping provisions, ultimately the doctor's value system, which rightly prioritizes the mental, as well as physical, wellbeing of the patient, may well conflict with the prevailing anti-doping morality.

It cannot be doubted that doctors are involved in the doping of athletes. Doctors are increasingly being seen as the protagonists in doping, even attracting accusations of taking part in "medically assisted doping".[9] The statistics do not establish the degree to which this involvement in doping in sport is deliberate or happens out of ignorance however it has been reported that 61% of performance-enhancing substances supplied to amateur athletes were prescribed by doctors[10] and a survey of 400 Surrey GPs found that 12% of respondents believed that a doctor has the right to prescribe steroids for non-medical reasons.[11] Of those doctors who responded to the survey, 18% had been asked to prescribe banned drugs to athletes. If these figures are repeated nationwide or worldwide, then clearly doctors will at some time be confronted by this problem whether directly involved in sports medicine or not.

Logically, such statistics cannot surprise those involved in anti-doping. Indeed the Code specifically anticipates violations on the basis of the doctor/athlete relationship. Under Article 10.5 of the World Anti-Doping Code (the Code), an athlete will not escape sanction by claiming that the banned substance was prescribed by a doctor. As the explanatory notes state "a sanction could not be completely eliminated on the basis of No Fault or Negligence ... [as a result of] ... the administration of a prohibited substance by the Athlete's personal physician or trainer without disclosure to the Athlete (Athletes are responsible for their choice of medical personnel and for advising medical personnel that they cannot be given any prohibited substance)". As was stated by the Court of Arbitration in Sport (CAS) in the Torri Edwards case:

> "It would put an end to any meaningful fight against doping if an athlete was able to shift his/her responsibility with respect to substances which enter the body to someone else and avoid being sanctioned because the athlete himself/herself did not know of that substance".[12]

If WADA is disinclined to charge governing bodies with a mandate to provide adequate and effective anti-doping education, for example, then how is an athlete to understand the nature of side effects of a particular substance? Furthermore, the current prioritizing of anti-doping of detection over education may be partially responsibly for the re-alignment of the athlete's values.

If this assessment of the changing relationships is correct then it might be possible to anticipate a change in the focus of legal attention in future away from the legal obligations and responsibilities of the athlete/governing body relationship toward the legal obligations and responsibilities of the doctor/athlete relationship. If indeed athletes are turning to doctors for advice on, and supply of, performance enhancing drugs, then a plethora of complex medico-legal issues are raised concerning the doctor patient/athlete relationship.

Consent

The two most likely scenarios upon which the law may be expected to adjudicate are firstly where the athlete was unaware that the substance prescribed by the doctor was a banned substance i.e. the athlete was banned and suffered financial loss as a result of the doctor's treatment or secondly that the athlete was unaware that the substance prescribed by the doctor would damage their health. At the heart of both of these scenarios is the validity of any consent to the use of these drugs being prescribed for or administered to the patient/athlete.

It is well established in English law that doctors owe their patients a "duty of care". This duty of care imposed on doctors towards their patients predates the famous dictum of Lord Atkin in *Donoghue v Stevenson*13 in 1932 by at least 110 years.[14] In *Bateman*, the court held that:

> "If a doctor holds himself out as possessing special skill and knowledge, and he is consulted as possessing such skill and knowledge, by or on behalf of the patient, he owes a duty to the patient to use caution in undertaking the treatment".[15]

It is also firmly established that part of that duty is to obtain the consent of the patient to any treatment or procedure. As early as *Slater v Baker* the court held that:

> "[I]t appears from the evidence of the surgeons that it was improper to disunite the callous without consent: this is the very usage and law of surgeons: then it was ignorance and unskilfulness in that very particular, to do contrary to the rule of the profession, what no surgeon ought to have done."[16]

For any consent to be valid in law, there is also a duty on the clinician to disclose any serious risk that the treatment or procedure may pose to the patient. English law has not served patients well in this respect as evidenced by the statements of Denning LJ (as he was then) in *Hatcher v Black*17 where the plaintiff, a singer, had been told when they asked of the risk of the procedure to remove a toxic goitre that there was none. The surgery resulted in her vocal cords being paralysed. Denning LJ noted that it was not general practice among doctors to disclose risks associated with medical treatment and therefore held that the doctor was not liable at law for the harm suffered by the plaintiff.

Although this decision may seem harsh from the perspective of the patient who may have opted to decline treatment had they known the risk that their career would be at an end, there is no doubt that in law it was correct. The decision must now be read in the light of the instructions to the jury given by McNair J. in the seminal case of *Bolam* that:

> "A doctor is not guilty of negligence if he has acted in accordance with a practice accepted as proper by a responsible body of medical men skilled in that particular art."[18]

To apply this to sportsmen and women; should an athlete seek medical attention for an illness or injury for which a banned substance is the medically indicated treatment, there will be no cause of action should that athlete subsequently be banned as the athlete has freely consented to that treatment. The physician has acted in the best interests of her patient and would have reached the standard of care required by the Bolam test. If though that same athlete has informed the doctor that they will not consent to treatment with a substance that is on the banned list, but the doctor treats with a banned substance because it is the best or only viable treatment, there will in all likelihood be liability in negligence. Even though the doctor believes that she is acting in the best interests of the patient, the wishes of a competent patient must be respected. A possible defence could be raised if it could be shown that the athlete was under such emotional pressure from external factors, such as trainers and agents, that the consent was vitiated due to undue influence.[19] Unless though the condition is life threatening, it is unlikely that such a defence would suc-

9 Laure, P., Binsinger, T. and Lecerf, T. "General Practitioners and Doping in Sport: attitudes and experience" (2003) 37 Br. J. Sports Med. 335, at 335.
10 Laure P. (1997) Doping in Sport: Doctors are providing drugs *Br. J.Sports Med.*, 31 258-259.
11 Greenaway, P. and Greenaway, M. "General Practitioner Knowledge of Prohibited Substances in Sport" (1997) 31 *Br. J. Sports Med.* 129, at 130.
12 Torri Edwards, CAS OG 04/003, c. 5.12.
13 [1932] AC 562.
14 *Pippin v Sheppard* (1822) 11 Price 400.
15 *R v Bateman* (1925) 41 TLR 557.
16 *Slater v Baker and Stapleton* (1767) 2 Wils. K.B. 860 at page 862.
17 *Hatcher v Black* [1954] CLYC 2289.
18 *Bolamv Friern and Barnet Hospital Management Committee* [1957] 2 All ER 118, at page 122.
19 *ReT* (Adult: Refusal of Treatment) [1992] 3 WLR 782.

ceed, especially if there are alternative treatments that would have been acceptable to the athlete even if not the best treatment available. Providing the patient is judged to have the capacity to refuse consent, and in law there is a presumption of capacity[20], then no matter how illogical or even repugnant the decision may appear to the clinician, they must respect the wishes of the patient.[21]

Although the paternalistic attitude of the courts and the medical professions towards patients is declining, in the area of disclosure of risk it can still be seen to be holding its own. The foremost precedent on disclosure remains *Sidaway*22, where it was held that it was not necessary to disclose the 1% risk of a catastrophic outcome to spinal surgery. Although the recent decision in *Chester v Afshar*23 seemed to shift that position as the House of Lords held that an off-the-cuff statement by the surgeon that he had not crippled anyone yet, was not an adequate response to a specific question on the risk of spinal surgery. The facts of *Sidaway* and *Chester* are alarmingly similar, with both procedures presenting a 1% risk of catastrophic outcome (the paralysis of the patient) and both patients asking specific questions about the risks of the procedure.

In *Chester*, the Court held that there was liability for the non-disclosure of even a 1% risk if asked a specific question, but the belief by some commentators that this represented a shift in the law was erroneous. *Chester* reconfirmed *Sidaway*; the cases can be distinguished on their facts. In *Sidaway*, the court chose not to believe the plaintiff's assertion that she would have significantly delayed the surgery had she known the risks, whereas in Chester, the court believed the claimant.

The central issue surrounding the disclosure of risk and the validity of consent then becomes how much information about the risks involved in a treatment or procedure is required to be disclosed by the doctor for a consent to be valid. This is governed by the "Bolam Test"[24] - what would a responsible body of medical professionals reveal to their patients?

This standard of disclosure would only apply to therapeutic treatments. There may well be considerable legal debate over the therapeutic nature of performance enhancing substances in the case of an athlete with no physical medical condition. A doctor may well be considered to be acting responsibly by treating with banned substances an athlete whose mental well being may be adversely affected by their withholding. If prescribing performance enhancing drugs are not considered therapeutic and may indeed harm the health of the athlete/patient, the standard for disclosure must be far higher. Indeed, as there is neither any statute nor case law to guide the medical practitioner, the best comparator would be medical research, where the physician is required to disclose all foreseeable risks. Although in 2006 the British Medical Association (BMA) published recommendations on education and information on doping in sport[25], no mention was made of consent as it was probably assumed that doctors would not participate in such activity. English courts have not yet had to consider this issue, yet, so it is necessary to apply the research standards on the disclosure of risk as the only appropriate comparator available.

The Medicines for Human Use (Clinical Trials) Regulations 2004 Schedule 1 Part 2 states in section 1 that:

> "Clinical trials shall be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki, and that are consistent with good clinical practice and the requirements of these Regulations."

Section 9 continues:

> "Subject to the other provisions of this Schedule relating to consent, freely given informed consent shall be obtained from every subject prior to clinical trial participation."[26]

It is necessary to determine not only that consent is given voluntarily and that the subject be fully informed of the risks, but also that "external factors had not exerted so much pressure on her that she felt she had no other option but to agree to take part".[27] Although referring to subjects taking part in clinical trials, the relevance to athletes subject to the pressures to win and the financial rewards, it seems unlikely that any consent to the taking of performance enhancing drugs be truly given voluntarily.

As stated in the Regulations, they do conform to the Helsinki Declaration which states in Article 1(9) that:

> "In any research on human beings each subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort that it might entail ... The physician should then obtain the subjects freely given consent preferably in writing."

These same requirements are repeated in the European Union Clinical Trials Directive which defines informed consent in Article 2(j) as being a decision which is "taken freely after being duly informed of its nature, possible risks and benefits of the procedure". Possibly the clearest statement on the need for fully informed consent from participants in non-therapeutic clinical trials came in the Canadian case of *Halushka v University of Saskatchewan* where Hall J. stated that[28]:

> "The subject of medical experimentation is entitled to a full and frank disclosure of all the facts, probabilities and opinions which a reasonable man might be expected to consider before giving his consent."

This is where the analogy arises to the issue of doping in sport. Although the conducting of non-therapeutic clinical trials would generally be seen as being for the public good and doping more likely to be regarded as contra bonos mores, neither activity is undertaken to either maintain or improve the health of the subject, though this may well be a positive side effect. As the prescribing of performance enhancing drugs is not a therapeutic treatment and, like some clinical trials, may well cause harm to the subject, an interesting legal scenario would arise if fully informed consent of the athlete were not acquired before proceeding with any "treatment". Should an athlete request performance enhancing drugs from their doctor when there is no medical indication that they are required, and the physician follows the wishes of their patient but fully informs them of any associated risks, then clearly no action would lie on behalf of the athlete should they in fact succumb to those risks. If on the other hand, the athlete is not fully informed of the risks associated with any performance-enhancing drug, then it could be argued that any consent given by the athlete is vitiated. Under either scenario, any action brought by the athlete for losses resulting from any ban should they be caught would be unlikely to succeed.

Criminal Conspiracy

This in itself though does raise a dilemma for the doctor as they if they have the written records of the freely given consent as a defence against any civil liability, they are also collecting evidence that they have committed a criminal act. Although the athlete in using performance-enhancing drugs may not have committed a criminal offence, by consenting to a doctor prescribing or administering those drugs may well be involved in a criminal conspiracy for the purposes of section 1, Criminal Law Act 1977 (as amended). So that in providing evidence in defence to a civil action by the athlete, the clinician will also be providing evidence of their guilt to a criminal offence and also opened their patient to criminal charges.

This discussion though could be argued to be moot because even

20 *Re C* (Adult: Refusal of Medical Treatment) [1994] 1 WLR 290.
21 *St.* George's NHS Trust v S [1997] FLR 426, per Judge LJ.
22 *Sidaway v Board of Governors of the Bethlem Royal Hospital & the Maudsley Hospital* [1985] AC 871.
23 *Chester v Afshar* [2004] 3 WLR 927 HL.
24 Above.
25 BMA "Drugs in Sport: the Pressure to Perform" ttp://www.bma.org.uk/ap.nsf/Content/Drugs+in+sport.
26 Emphasis added.
27 Jackson, E. "Medical Law: Text, Cases and Materials" (2006) Oxford University Press, at page 485.
28 *Halushka v University of Saskatchewan* [1965] 53 DLR (2d) 436 at page 873.

though a doctor were to adequately inform an athlete/patient of the risks of a performance enhancing drug, the validity of the consent in criminal law would at best be questionable as *R v Brown*29 clearly demonstrated that it was not possible to consent to a criminal act that may result in serious harm. It can be seen that in this instance as in others within the doctor patient relationship, there is a divergence between the civil law and criminal law because in civil law the maxim is "*volenti non fit injuria*" - to a willing person no wrong is done. It could also be argued that a further defence for the physician would be that the athlete should not be awarded a remedy because they would be basing their claim on an act that is itself unlawful (the criminal conspiracy); "*ex turpi causa non oritur actio*" - an action does not arise from a base cause. This of course assumes a relationship of equals as between the athlete and doctor. It could though be argued that between doctor and patient the relationship is never one between equals as it is the doctor with all the expert knowledge and therefore power.

Professional Misconduct

Additionally, there is always the residual possibility that an athlete may draw the attention of the General Medical Council (GMC) to the fact that their doctor has prescribed performance-enhancing drugs where there is no clinical indication that they are required. This would lay the doctor open to disciplinary action by the GMC for serious professional misconduct even though the athlete actively sought such treatment and may therefore have no legal redress.

Obviously, doctors should always act in the best interests of their patient, though it may be possible to argue in this scenario that the clinician is so acting. It might be reasonable for the doctor to argue that with the pressures on the athlete to succeed being so intense, and that their only chance of "winning" is to use performance enhancing substances, the doctor may be acting reasonably in prescribing these substances for the patient's mental wellbeing. To prevent psychiatric harm, a doctor may well feel justified in undertaking such an unlawful act. It is though unlikely that such a defence would succeed as there is a better alternative course of action: therapy.

Confidentiality

A doctor approached by an athlete seeking access to performance enhancing drugs is also faced with another problem. Medical practitioners owe their patients a duty to maintain the confidences revealed during any consultation.[30] As Lord Keith stated:

> "The law has long recognised that an obligation of confidence can arise out of particular relationships. Examples are the relationship of doctor and patient, priest and penitent, solicitor and client, bank and customer."[31]

That duty has been demonstrated not to be absolute. In W v Egdell[32] where revealing the results of a psychiatric test to the prison service was held to be an overriding public interest. The revealing of medical information that has the nature of an overriding public interest must only be revealed to the appropriate authority.[33] Two questions need to be answered for the clinician at this point, is the fact that an athlete is using, or considering using, performance enhancing drugs an issue in which there is an overriding public interest and secondly, if it is, to whom should information on drug use be revealed? As this is not a criminal matter at this point and there is no public safety issue, the only reason to reveal such information is that there is a public morality issue and as morality is by and large a relative question, it is unlikely that this issue would be an issue of overriding public interest as opposed to the prurient interest of the public, which is definitely not the same thing. If though it transpires that there is an overriding public interest, there may be little point in revealing the information to the police as the use of most performance enhancing drugs is not necessarily a criminal offence. That leaves only the relevant regulatory body for that athlete's sport.

Conclusion

As the protection of the health of athletes is one of the three criteria used to establish the suitability of a substance on the "banned list" it is reasonable to assume that the health of athletes is one of the central tenets of the anti-doping movement. The Code however does not attempt to impose education policies on governing bodies with anywhere near the same zeal as it advocates detection and punishment.[34] It is arguable that all good regulatory frameworks must strike an appropriate balance between "carrot" and "stick" otherwise they run the risk of being ineffective. It would be ironic if the WADA Code, with its emphasis on detection and punishments, is effectively pushing athletes away from the anti-doping values of their governing body and thereby counterproductive in protecting the health of athletes.

It is not the intention of this article to vilify doctors or their values nor to question the integrity of the anti-doping movement. It is accepted that most doctors observe the highest of professional standards. It is just that those standards might not always align themselves exactly with those of the governing bodies of sport.

The principle conclusion of this article is that is that the likely consequence of this philosophical re-alignment is that the legal focus will shift from the athlete/governing body relationship to the athlete/physician relationship which necessitates a re-evaluation of the crucial legal issues.

It is not the purpose of this article to provide a detailed legal commentary on these crucial doctor/athlete issues. However in identifying consent, disclosure, criminal conspiracy and issues of medical ethics and explaining the logic of this underlying shift in the migration of loyalty paradigm it identifies a change of legal emphasis in anti-doping matters. The legal and ethical consequences of the doctor/athlete relationship in the context of anti-doping is largely uncharted waters. There is an urgent need for WADA and medical governing bodies to investigate further the nature of and tensions that exist in this important relationship.

29 *R v Brown* [1993] 2 WLR 556.
30 Stephens v Avery [1988] 2 WLR 1280.
31 *A-G v Guardian Newspapers* (No. 2) [1990] AC 109 HL.
32 *W v Egdell* [1990] 1 All ER 835.
33 *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513.
34 Article 18.2 of the WADA Code merely states that "each Anti-Doping Organization should plan, implement and monitor information and education programs. The programs should provide Participants with updated and accurate information on [inter alia] ... health consequences of doping". (italics added).

ASSER International Sports Law Centre

Conferences, Round Table Sessions, etc.

- The abolition of the transfer system in professional football (The Hague 1996);
- The television rights of professional football and European competition law and policy (The Hague 1996);
- The sports boycott of Nigeria: sports, politics and human rights (The Hague 1998);
- The international regulation of doping in sport: towards harmonisation? (The Hague 1999);
- The Americanisation of sports law - the American and European sports models compared (Utrecht 2000);
- Sport and the law in the People?s Repuhlic of China (The Hague 2000);
- The taxation of international sports income (Utrecht 2001);
- The future of professional football leagues in Europe: competitive balance and fair competition? (Rotterdam 2001);
- Sport and pensions (Utrecht 2002); ***(continued on page 117)***