Beyond Consent? Paternalism and Pediatric Doping

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In this essay, I argue that the issue of pediatric/adolescent doping is one that merits serious philosophical attention. I consider whether an adolescent who is legally competent to consent to medical pharmacologies such as contraceptive pills ought to be allowed to consent to doping products. The former case, well known in medical ethics, is often referred to as "Gillick competence" following the court case brought by the mother of an adolescent (Mrs. Gillick) whose consent was first considered satisfactory by her medical doctor and then the Law Lords of Great Britain. I first discuss issues of vulnerability and exploitation of adolescent athletes that might underwrite a soft paternalistic response. I go on to argue that the harms attendant to doping, as opposed to the regulated use of the medical profession to prescribe oral contraceptives, are of a potentially greater magnitude to the successful adolescent patient/sportsperson themselves in contrast to the relatively well known risks of contraception. I also argue that the complexity of the weighing of potential harms and benefits are such that informed consent cannot be reached by adolescents. Moreover, given the public prominence of the WADA antidoping legislation, and the general public support for them, there will necessarily be a lack of transparency in the potential consent process, which undermines any audit for the accountability of the consent process. I conclude that Gillick competence ought not, therefore, to be viewed as a precedent for pediatric or adolescent consent to doping and that the "weak" or "soft" paternalistic prevention of doping is justified.

The issues that orbit around the use of performance enhancing drugs has been one of the most discussed issues in both descriptive and normative sports ethics. As is well known, the worlds of elite sport are regulated by the World Anti Doping Agency (WADA) whose code (WADC) defines and proscribes certain processes and pharmacological products that comprise doping and which receive various bans from athletic competition as their sanction. The WADC, however, says nothing in detail or in particular about pediatric doping, nor does the international professional association for sports medicine (International Federation of Sport Medicine [FIMS]). There is then something of a lacuna here. With respect to adult doping I think it is fair to say that a significant number of philosophers (24; 43; 44; 52) are skeptical of the legitimacy of the bans on doping. A few notable scholars...
and scientists have written explicitly against public and political opinion and declared that the bans should simply be revoked if they are grounded purely on ethical considerations (24; 32; 49). Moreover, that skepticism has found its way into such august medical and scientific journals as *Nature* and *The Lancet*. Their liberalizing or libertarian approaches to doping are sometimes driven by a quasi-medical lobby who advocate the use of technology for all aspects of human enhancement and who view sport as a key vehicle for their legitimization. There is always the danger, in supporting the banning of certain substances of practices that one is considered a Cassandra or a timid, narrow-minded, conservative.\(^5\) Worse, for those who value their academic freedom, one might be seen as an apologist for global institutions such as the International Olympic Committee (IOC) or WADA.

In his excellent analysis of paternalism with respect to the doping issue, Brown (11) does not discuss the issue of pediatric or adolescent\(^7\) doping in a sustained way\(^8\). He does write, however, of the potential vulnerability of young people to the harmful effects of doping (11:18) with risks “far outweighing any possible benefits of temporary superior athletic prowess.” It will be thought by some that the wrongness of pediatric doping is self-evident. Perhaps this explains the lacuna in the pronouncement of official organs such as the FIMS, the IOC or WADA. To what extent is this presumption warranted?

What particular problems are generated when the populations under consideration are themselves legal minors? In this essay I shall raise a number of problems and consider one central difficulty within the issue: the lack of capacity to consent to doping in an informed manner by a child or adolescent. Now since doping ought, according to the skeptics, to be permissible for adults it is at least open to question whether the same opportunity ought to extend *ceteris paribus* to legally competent children or adolescents. Moreover, there appears to be a prima facie precedent in medical ethics law where respect for the autonomous desires of one’s patients is thought to be of paramount importance whether they are adults or, for the purposes at hand, competent minors. Thus I consider whether the notion of well known legal test of “Gillick competence” to contraception\(^9\) in the absence of parental consent, sets a precedent for the child or adolescent who wishes to dope in order to enhance their sporting performance. Both scenarios certainly share at least the similarity that the child or adolescent might be considered competent to frame their conception of what is in their best interests.

In exploration of these issues I distinguish, for the purposes of argument, two aspects of the problem. First, I argue that there are particular and specific good grounds for paternalism with respect to sports legislation against pediatric doping viz. the exploitation of what is effectively a vulnerable population. Secondly, I compare and contrast Gillick competence with the possibility that pediatric might competently authorize a physician to assist their doping. I conclude that the former should not be thought of as a legal or ethical precedent for the latter. In order to buttress this position I present a range of evidence that underwrites the precautionary disposition I argue for and, in particular, argue that any consent an adolescent could proffer would be invalid due to an inability to weigh (with sufficient informedness and comprehension) the potential benefits and harms arising.
Is Pediatric Doping Really a Problem and If So What Kind of Problem Is It?¹⁰

One might reasonably ask whether the question at hand is a hypothetical one. Do adolescents really engage in doping behaviors? A short answer suffices: indeed they do. There is certainly international evidence of a small but significant proportion of adolescents engaging in doping practices. The data available must, however, be treated with caution on a number of grounds. In the first instance, the dominance of research emanates from North America (5). It does not follow that the problem exists predominantly there. This may or may not be true. It merely indicates that more research is being carried out in the USA than anywhere else. Recent epidemiological surveys in the USA suggest that most children experiment with drugs such as alcohol, marijuana, and tobacco (26). Why should doping products be any different? Although mindful of the fact that they are USA-based, recent review articles suggest between 3 and 12 per cent of adolescent males have used anabolic androgenic steroids, (hereafter AAS) at some point (59) while others present figures of between 4–11 per cent (14) while an earlier study puts the rates at between 5 and 11 per cent (2).

A second methodological point refers to the construction of the research tool used to gather the data on pédiatrie doping. Kanayama et al. (30) suggest there may be methodological weaknesses in such studies where high prevalence rates are deduced from questionnaire-reliant methodologies. In particular they express concern regarding the over-reporting of steroid use in females, although they also consider prevalence rates for adolescent males to be over-estimated. Kanayama et al. (30) criticize questionnaires that refer generically to “steroids” without further qualification. They argue that this leaves open the possibility of conflation with the use of nonperformance enhancing steroids such as corticosteroids (commonly used painkillers), which may lead the respondent to think that steroids are freely contained within sports supplements. The authors also criticize questions that refer to steroid use “without a doctor’s prescription.” This is especially important since this may be taken to infer that doctors commonly prescribe steroids whereas AAS prescription for girls is almost unheard of. Also reference to the number of ‘times’ steroids have been taken is misleading (30) because AAS tend to be taken in courses. ‘Cycles’ of AAS can last between 6 and 12 weeks (2). It is suggested that as knowledge about these drugs has developed, through their wide reporting in the media, the likelihood of over reporting steroid use through response to such ambiguities has reduced (30). Summarizing their position, Kanayama et al. (30) maintain that earlier prevalence rates are unduly influenced by ambiguous research questions. Having established that there is such a phenomenon as pédiatrie doping (albeit one that appears more concentrated in the context of American high school athletics and one of whose prevalence we are not certain) we must also note that the practice is gendered. The use of AAS by females is reported to be lower, around 1–2 per cent admitting using steroids (59).

What kinds of substances are abused in the name of athletic success? Probably the greatest single family of substances ingested are AAS that are used to promote muscle growth. It is widely agreed that power-based sports are most vulnerable to doping and these are most likely to feature on a list of substances desired by pediatric athletes who are tempted to dope (6). But pediatric doping is
not confined to AAS use. Laure et al. (36) in a study of high school athletes in France, found of the four per cent of athletes who admitted doping at least once, 13 per cent specified peptide hormones, this group including the human growth hormone, as well as tamoxifen and EPO. Wanjek et al. (56), also indicated use of growth hormone by German adolescents, 0.4 per cent of respondents compared with 0.7 per cent having used AAS. As Allen and Frost (1) report, however, there is a lack of data concerning the psychosocial benefits or harms from recipients of human growth hormone even in therapeutically indicated populations. This point in particular, regarding the uncertainty of known effects is an important component of the case for paternalistic measures with respect to pediatric doping.

Having established that the problem of doping is extant in adolescent sports, how ought we to frame our ethical responses to it? As I have said, perhaps most philosophers of sport, sport pedagogues, and parents shudder at the thought of the untrammeled pursuit of athletic success that would drive their children or charges to such measures and would embrace a paternalistic stance against the would-be pediatric doper. Justifying the intuitive wrongness of pediatric doping, and the need for some for paternalistic protection, is another matter. And a fuller consideration of the issues would need to situate the ethics of pediatric doping in the broader context of philosophical discussions relating to children’s rights to self-determination, or the much discussed right to an open future (19; 22; 53).

Given, however, the prima facie presumption of harm prevention for children it would seem we would need to consider the adoption of some “weak” or “soft” (21; 23 respectively) paternalistic measure which refers to the intentional overriding of a person’s preferences when that person is thought incompetent to form a sufficiently rational and autonomous conception of their own interests. By contrast “strong” or “hard” paternalism (21; 23 respectively) refers to the over-riding (or at least supplanting) of the desires of competent adult persons, a policy he thought ought only to apply in special cases. Our scenario, referring as it does to legal minors, thus only invokes the possibility of “weak” or “soft” paternalism. Defenders of the child’s potential competence may argue that where a child has capacity to comprehend the action and its risks and benefits any paternalistic intervention will be a “hard” or “strong” one. I shall argue, however, that only “weak” or “soft” paternalism typically applies in the context of pediatric doping. In defending this position I explore the possibility of constructing a rationale for justified paternalism in two phases: the first is that the population under consideration are vulnerable and therefore in need of protection, since the sports system (or key actors therein) exploits their absolute desire for athletic success. Having set out the paternalistic case I move on to a more in-depth discussion of the powers of consent of successful pediatric athletes.

Are Pediatric Athletes Vulnerable?

What does it mean to say that pediatric athletes are vulnerable? To what or whom are they vulnerable? First, it is necessary to accede that something more than the intrinsic vulnerability of all humans needs to be established. Hobbes (27) long ago pointed out even the strongest are vulnerable to attack in their sleep. Moreover, most readers of this journal, beyond the first flushes of youth, can testify to their
being vulnerable to the ravages of aging and the reality of diminishing physical and psychological powers. What more can be said of pediatric athletes for us to consider them vulnerable to the extent of needing paternalistic protection?

Being youthful, let us agree without argument that the life plans of adolescents’ norms and identity-constituting attachments are to a certain degree in flux. That is to say, their life plans are neither fully formed nor fully informed. This will render them (potentially at least) vulnerable to certain controlling influences that may undermine their rational and autonomous decision making. Three such forms of improper influence: coercion, manipulation and persuasion can readily be identified (8: pp. 94–98). The limit case for improper influence was witnessed in the state sponsored and medically supervised training of young East German athletes in the 1970s and 1980s (50). Less dramatically, what often renders elite pediatric athletes particularly vulnerable, and requiring protection, is the manipulative or even coercive character of their relationship in the athlete:coach:parent triad. The wealth of evidence illustrating excessive parental influence over their children’s future sports careers should not be underestimated (19; 53).

In order to develop this first point further it is necessary to stipulate a context for my concerns. It may be difficult to conceive why recreational pediatric athletes would succumb to the temptations of banned performance enhancing processes or products.12 For present purposes, however, I shall restrict my discussion of doping to already successful adolescent athletes. I have in mind contexts as diverse as senior high school baseball, basketball and football in a large US cities, or professional soccer academies for youths in Europe or South America, or even the practice of recruiting 5 and 6 year old jockeys to professional camel racing in the middle east (17). What these scenarios share, is the potential for exceptionally lucrative financial contracts and high social status even from a very young age.13

I suggest that what makes elite pediatric athletes vulnerable to harms is the presence, whether real or perceived, of these enormous financial incentives whether as contracts or potential contracts (17). The very presence of such inducements, and the international market in youth sport labor from which it has emanated, has the power sufficiently to corrupt clear thinking in relation to the adolescents’ future interests.

Taking unreasonable risks is not something we generally promote to the young. I agree with Russell (48) that we ought not to inure children from all possible harms arising from sports and indeed that exposing them to a restricted measure of them may indeed promote virtuous dispositions and powers of practical reasoning of value to them at all stages in their lives. But where the temptation to pursue highly specialized and potentially risky careers, ones that increase the possibility of harms, and/or foreclose broader development and thereby limit vocational and other social opportunities for growth and well-being, it is not in a child’s interests that they be allowed to pursue them.14 I therefore consider these lucrative inducements to be undue influences on the adolescent athlete.

I am aware that it might be argued that these influences regularly affect competent adults who still favor risking their future health in elite or professional sport. Nevertheless, we typically allow their participation in sports out of a respect for their freedom to choose the activities they wish insofar as they do not harm others.15
Leaving aside coercion and manipulation, which are unambiguously unethical practices, I have argued that the mere presence (or perception) of very significant financial rewards along with the tangible and ongoing elevated status of peers renders the adolescent vulnerable to decisions that do not properly weigh potential rewards and risks with present and future best interests. I am mindful that the discussion so far elides a potentially important distinction between children and incompetent adults. Thus far the argument would apply to both categories. In what follows, however, I shall restrict myself to pediatric contexts.

I have thus far assumed that successful adolescent athletes are vulnerable to the extent that their life stage does not typically permit autonomous decision making on matters of potential magnitude as is the case in doping. This assumed incapacity is compounded by the presence of significant financial rewards that may be thought to unduly influence their decision making, especially in the context of pushy parents or coaches. This argument may not persuade those who think that children have greater powers of autonomy than I have assumed thus far. I shall therefore proceed to argue that soft paternalism is necessary to protect pediatric sports populations from exploitation before discussing the shortcomings of their capacity autonomously to consent.

**Exploitation, Elite Sports and Pediatric Doping**

Everyday usage of the words “exploit” or “exploitation” does not necessarily embody negative connotations. People speak unproblematically about exploiting marketing opportunities in ways that are not morally troublesome. To exploit a thing with moral standing however is wrongful by definition. But why ought we to think of the elite pediatric sportsperson as being exploited in his pursuit of doping products or practices? In developing this discussion I will draw upon Stephen Wilkinson’s defense of the (fairly remunerated and consensual) trade in organ selling even though I am not sympathetic with his positive conclusions for that particular project.

With respect to ethical usage, to exploit something is to use it wrongfully. So exploitation becomes a species of instrumentalization. Wilkinson writes “A exploits B (in this sense) if A treats B merely as a tool for, or a means of, achieving A’s goals.” (58: p. 33). Underpinning what is morally wrong with this treatment of persons are two Kantian principles. First, to treat someone instrumentally is to offend the Categorical Imperative by treating another person merely as a means (or instrument) to our own ends. Secondly, to treat another as fungible is to conflate the concepts of price and dignity; the former applies to all objects and subsumes their “replaceability” but the latter does not, and to give a price to human persons is to offend their dignity.

Developing on these two foundations, two senses of exploitation can be discerned: “disparity of value” and “wrongful use.” The two instances of exploitations differ in that what is wrong is the particular use in question. Wrongful use exploitation arises where one is used as a mere instrument for another’s goals and thereby fails to treat the other as an end in themselves. Cases such as these abound in sports where surrogate glory or wealth is sought through the auspices of the adolescent or child. Perhaps the worst of recent cases arose in the Indian subcon-
tinent where a child of 4 was being trained to run marathon distances clearly, in part, for the financial well-being of the coach. Wilkinson reserves the label “wrongful use exploitation” with “instrumentalisation” (58: pp. 34–35) for cases such as these. It seems fairly clear that to force one’s children to commit to work in elite sport for economic advantage (however mutual) is an instrumentalization of the child, but it is also the case that it offends something in the irreplaceable nature of childhood itself understood in a linear way: that the early stages of life are to be valued on their own terms and cannot be regained once past. In such cases the adolescent, in the absence of parental and other’s undue influences, instrumentalizes his or her youthful body.

Moreover, exploitation can occur also in cases where one is unfairly used (under-rewarded). What we know of elite sports is that the vast majority of athletes will not earn the huge salaries we read about in Time or Sports Illustrated. That is not only the preserve of a tiny minority but also it is restricted to a relatively small sample of sports that are caught up in the commodified media driven-elect. So it seems reasonable to say, on the basis of the tiny conversion rate between the “hopefuls” and the “successfuls”, that putting one’s health at risk in the case of doping is a dangerous long shot (even when it is the only possible shot an athlete has).

Regarding unfair use exploitation Wilkinson writes: “Everything depends on the context in which the use takes place, on the relationship between the user and the used, and (most importantly of all) the quality of the used person’s consent.” (58: p. 43). His thesis is that where an individual is fairly rewarded there is no exploitation so long as the agreement to the conditions that are potentially deleterious to their well-being are properly understood and subject to the agent’s own informed desires. Thus far I have questioned whether the fair reward argument holds water since so few pediatric athletes ever succeed to the professional arenas of adult commercialized sports and that the potential rewards induce risks that otherwise would not be entertained. But for the purposes of argument let us assume that some children so gifted in the natural lottery, with the requisite character traits, and a lorry load of good luck, are indeed destined to make it to the big game. Ought they to be allowed to consent to doping? I shall explore the propriety of this state of affairs via an analogy with the Gillick competence of adolescents to consent to contraception.

**Gillick Competence: A Sketch**

Given that our present concerns are philosophical more than juridical, I shall offer no more than a sketch of the idea of “Gillick competence” and the subsequent “Fraser Guidelines” that are used widely in medical world in the UK at least. The term derives from the name of a parent, Mrs. Gillick, who brought a case against the National Health Service in the UK for allowing her 14 year old child to consent to contraception without her knowledge or authorization.

The case turns upon the principle of respect for autonomy to determine one’s life plan and the actions therein. Its *locus classicus* is John Stuart Mill’s arguments pertaining to noninterference and self-determination. Loosely put, persons should be able to do with their bodies and their selves as they wish so long as they are of
sound mind and do not harm others. Originally Mill held that ‘idiots and infants’ comprised the exception to his original formulation of the principle of noninterference/self-determination, but it has been extended in recent times to children who are possessed of the competence to understand the nature and consequences of the issue at hand. In medico-legal terms, the Gillick precedent allowed children who demonstrated the relevant competence to grasp the intervention(s) proposed, to accept or reject that treatment without parental authorization which had hitherto been normal practice. Might this precedent extend to a successful adolescent athlete, who wanted to dope?

Comparing and Contrasting Adolescent Competence to Consent to Contraceptive Treatment and Doping

Are there good reasons for thinking that children or adolescents could properly be thought of as “Gillick competent” to consent to dope? To begin with it will be useful to consider competence as a logically incomplete concept. It is analogous to the concept of fitness. One cannot properly ask the question whether X is fit, without specifying the purpose for which one is or is not. So, with the idea of competence to consent, we should not expect a universally applicable answer. The question does not permit it. If we wish to know whether someone is fit to give consent, we must ask whether they are competent in the relevant sense.

Culver and Gert (16) refer to this as task-oriented competence. For children or adolescents properly to give informed consent to the use of doping substances they must understand what they are being asked to do before they can competently give consent. Can we judge that children or adolescents are informable about the complex of benefits and harms that may attach to doping? We might have little confidence in the informability of pediatric athletes if we based our judgment upon what we know of present young elite athletes. Understanding the pros and cons of contraception seem straightforward by comparison. The young cyclists interviewed in Vest Christiansen’s (54) study had, unsurprisingly, heard about the blood boosting drug EPO, but knew little about other potential doping agents such as growth hormone, steroids and amphetamines and their potential effects. Though not informed as regards doping then, to what extent adolescents are informable and capable of comprehension of the task at hand?

Given the scientific controversy that surrounds the efficacy in addition to the health-threatening effects of various products that fall under WADA’s banned list, it is difficult to comprehend how anyone without a degree in the relevant biomedical sciences could come to a reliable understanding of the scientific benefits and costs or risks of all the various doping substances and processes—especially given that it is widely thought athletes have used therapeutic drugs only tested not tested on healthy populations, or that they use off-label medications, experimental drugs, and that they are often required to “guesstimate” appropriate dosages and cycles. This lack of knowledge of side effects following usage may undermine both adult and adolescent populations—at least for many doping products and processes.

This picture of uncertainty regarding doping effects is not homogeneous. While side effects of AAS are relatively well known for adults, those for creatine
(a very widely used synthetic substance used for the production of explosive power and which is not banned) or recombinant human growth hormone (banned) and other products are not known in full either by scientists or physicians. As I have noted above doping use may be thought to be experimental without the protocols of (e.g.) randomized controlled trials or evidence based decision making. And this may be because of the experimental nature of the drug, or its unique application to nontherapeutic purposes, or merely that its efficacy in therapeutic cases renders uncertain its effects in patients not suffering from any medical condition. Moreover, a more general point about pediatric pharmacology is worth making. It is well known that very little of today’s pediatric prescription drugs were ever tested on pediatric populations (15). Indeed it is widely thought unethical to experiment on populations without direct therapeutic need and benefit (20). And so the pharmaceutical industries statistically extrapolate dosages from adult populations. The lack of awareness of the effects of performance enhancing drugs on pediatric populations is expounded by the American Academy of Pediatrics Committee on Sports Medicine and Fitness (3: p. 1104):

Virtually no experimental research on either the ergogenic effects or adverse effects of performance enhancing substances has been conducted in subjects younger than 18 years.

This gap in understanding threatens to radically undermine the possibility of informed consent by adolescents. It also brings into serious doubt even the possibility of adults or physicians advising adolescents as to what would be in their best interests so as they could come to an informed decision.

Nevertheless, most professional bodies in relation to sports medicine and sports governance assert the harmfulness of AAS, and potential of other such substances, and this is one of three criteria by which such products and processes are banned by WADA. Baker et al. (7: p. 481) note that:

The FDA in the United States has received more than 800 reports of adverse effects associated with use of products containing ephedrine alkaloid since 1994. These serious adverse effects include hypertension, palpitations, neuropathy, myopathy, psychosis, stroke, memory loss, heart rate irregularities, insomnia, nervousness, tremors, seizures, heart attacks, and death.

If we compare this Pandora’s Box with the potential physical and psychological harms of contraception it seems that both the scope and the magnitude of potential harm is magnified in doping. While the ingestion of oral contraceptives is not entirely without risks it, is by comparison, regulated and the professional practitioners who prescribe it have extensive knowledge and have undergone professional training. Moreover, it is performed under conditions that emphasize the health and safety of the patient. Given the public prominence of the WADA antidoping legislation, and the general public support for them, there is a resultant lack of transparency in the potential consent process. This lack of transparency renders all but impossible any audit for the accountability of the consent process. Compared, however, with the unregulated practice of ‘ethnopharmacologists’ (often entrepreneurial graduates in biochemistry who have little or no concern for the health of those whom they supply drugs to (45)) it may be safe to assume
that the risks are rather more controlled—though clearly one could not be any-where near as confident with “backstreet abortions”, which may be more like-for-like in its comparison.

In certain communities the use of oral contraception may result in the excom-munication of the potential mother. This clearly constitutes an exception rather than the rule. Whether merited or not, however, doping cheats at the elite level face the full sanction of the sports communities which partly constitute their emerging identity. WADA’s rules indeed prevent those found guilty of doping even from training with their respective clubs or teams. Moreover, high profile doping cheats make good copy: there is little chance of escape from the media’s scrutiny and subsequent schadenfreude. In terms of status, those convicted are required to hand back those medals won under unfair conditions. Moreover, in the UK at least, those guilty of doping violations are required to pay back state funding since they have broken their contract to compete “clean.” Given the fleet-ing nature of athletic careers, many of which are not lucrative despite the public-ity given to footballers’ grossly inflated wages, being convicted of doping can mean serious financial hardship. It seems difficult to conceive of adolescents being able to consider so seriously the mid and long term consequences of getting caught which would be necessary for them to be considered competent to consent to doping. That much said the complex factors that attend abortive sur-gery are hardly less weighty. What may be said in their favor, perhaps, is the possibility of reversibility: except in tragic circumstances the potential mother may elect to become pregnant and give birth at a later date. The analogous option may not be realistic for the doping athlete who is caught since their period of excommunication is intended precisely to be an effective end to their athletic careers. With respect to adolescent contexts, it would be a strong minded indi-vidual indeed who continued to train at the highest levels for 1, 2, or 4 years while being unable to compete or receive financial assistance to allow them to focus on developing their athletic potential.

Another sociopsychological factor to be considered is whether Gillick con-sent to doping would be properly understood in relation to future addiction. We may cast drug abuse in sport more generally as a pediatric issue since the genesis of doping behavior can begin in adolescence. A further important consideration then will be something like a slippery slope argument; if we permit doping in pediatric sports will this serve to legitimize, for example, wider drug abuse, or even genetic modifications? It is a serious concern then that doping may lead the adolescent on a path to addiction to a point where autonomous decision making is itself undermined:

Youth with life choices and options that are perceived as being limited are more likely to engage in high risk behaviors, such as substance abuse and unprotected sexual activity. Youth may rationalize or perceive other social or personal “benefits” from substance abuse that override any identified health concerns. Many of them do not realize the negative consequences of drug use and abuse; some even believe that it is normal to use various drugs. The greatest risk for long-lasting dysfunctional patterns of substance abuse is the onset of use before age 15 (26: p. 394).
It might be argued that I am sliding together here issue of performance enhancing and social drug use. There is some truth in this claim but also some justification for it. One of the key issues regarding illicit doping is that of access. Athletes in some sports have potential access to doping products through the frequenting of, among other places, fitness gyms where off-label use of pharmaceutical is rife (45). So the elision, in terms of the possibility of gateway drugs, to increased access to other drugs is not unreasonable. A more substantial philosophical response to this position might be to say, well we must not conflate rational autonomy with prudence. Rawls' (47) well known thought experiment might apply here: ignorant of personal individuating facts (such as age, intelligence, ethnicity, sexuality and so on), rational agents necessarily choose prudent laws because they were unaware that they would benefit or be harmed by their future application. But why not entertain risky lifestyles? Why ought “chronological parochialism” (12) necessarily to prevail?

In relation to adult doping, Tamburrini (52) has questioned whether we may justifiably link this phenomenon with widespread drug abuse. This position is undermined, however, by the millions of dollars commercial companies pay to sports icons to promote their product based, as it is, on a wealth of data concerning the appreciation of market brands even by very young children. As Greydanus and Patel (26) note that a career of substance abuse may pivot around adolescent years thus we are properly protective of this time slice. Moreover, a recent international study found that those athletes who use ergogenic nutritional supplement use were more likely to report doping too (46). Perhaps the most important issue at hand here, from a public health perspective at least, is whether AAS or other preferred doping substances are “gateway drugs” (31). These substances are so described for the reason that their use increases the likelihood of progression to other drugs. Moreover, given the motivational differences between doping substances it is not clear how we should think of the most common substances such as AAS, EPO, or hGH. A questionnaire based cross-sectional study in Sweden of more than 2000 16–19 year olds, led Kindlundh et al. (33) to suggest that the motivation to enhance performance and body appearance has commonalities with other forms of substance abuse. Of course this in itself does not lend authoritative support for the application of the gateway principle. One might think that if the adolescent has gone to the point of using doping substances that the athlete has crossed a line in his attitudes toward rules and the perceived value of the perfection of his capacities. Why not go further? The point is moot. Perhaps what is most interesting is not the nature of the drugs themselves but the cultures into which the choices and behaviors are generated or the networks into which adolescents must operate if they are to access such drugs (31). But the evidence does not exist to warrant anything other than the application of a precautionary and thus soft paternalistic approach.

In this section I have presented argument and evidence regarding the complexity of which renders it problematic to think that adolescents might typically comprehend the nature of doping and its attendant benefits, harms and the risks and probabilities that pertain to them. And I have contrasted it with the relatively well known exposure to such in the case of consent to contraception in Gillick-like cases. Despite the palpable fact that physicians have assisted in pediatric doping, I have challenged legitimacy of the physician who would advise an ado-
lescent that it would be in their best interests to dope on the grounds of potential harm and the incompleteness of medical understanding of doping products and processes with nontherapeutic adolescent populations of which our hypothetical successful athletes are one.

**Conclusion**

I have tried to show how the issue of pediatric/adolescent doping is one that merits serious attention. While the philosophical literature on doping rarely considers pediatric populations, it seems the case that the legitimacy of their pursuance of these products and processes might be thought to fall under the conceptual province of “Gillick competence” to consent to contraception. In this case, as sometimes happens elsewhere in the doping debate (24; 49), we would be transposing a norm—like harm prevention—from medical ethics into the domain or sports ethics. Unlike the Gillick case I have tried to articulate the background to the successful adolescent sports world, the vulnerability of athletes therein and the tendency toward their exploitation. With specific respect to the capacity of adolescents to actively consent to doping I have adopted a precautionary approach. Although the gravity of both decisions is manifest, I have argued that the harms attendant to doping, as opposed to the regulated use of the medical profession to prescribe oral contraceptives or terminate pregnancies under conditions of nonparental consent, are of a greater magnitude to the successful adolescent patient/sportsperson themselves. I have also argued that the disputed scientific bases for the harms of pediatric doping are such that the informational requirements of informed consent render any would-be consent invalid and would undermine the legitimacy of a physician who advised an adolescent to dope. I conclude that Gillick competence ought not, therefore, to be viewed as a precedent for pediatric or adolescent consent to doping and that the “weak” or “soft” paternalistic prevention of doping is justified.28

**Notes**

1. This address was given as the Warren P. Fraleigh Distinguished Scholar Lecture for the International Association for the Philosophy of Sport, Tokyo, Japan, September 2008.
2. For historical overviews see Dimeo (18); Hoberman (28); Hoberman (29) and Waddington (55). For philosophical overviews see Brown (13); McNamee (38: pp. 177–193); Miah (43;44).
3. See http://www.wada-ama.org/en/. Accessed 17.05.09
5. For a critique of which see McNamee and Edwards (39).
6. See the caricature of the timidity of bioconservatives in Bostrom (9).
7. I shall use these terms interchangeably throughout the essay.
8. Though there has been descriptive ethical work in the area. For example, see for example Laure (34) and Laure and Binsinger (35).
9. I note that it has been suggested that the competence may even extend to adolescents who wish to have abortive surgery.
10. I gratefully acknowledge the assistance of Andrew Bloodworth with whom I compiled two reviews of literatures on doping ethics for UK Sport as part of social scientific studies on the values and norms of elite young athletes with respect to doping (40 unpublished; 41 unpublished). Parts of this section are reworked from those reports.

11. So as to avoid the appearance that this is a U.S. phenomenon, consider the research of Baker et al. (7) in the economically deprived Valleys of South Wales in the UK, who found 22 per cent of the respondents in a study of health club users used tamoxifen, a substance that is described as a ‘nonsteroidal antiestrogen for women with ductal carcinoma in situ (DCIS) and for women at high risk of breast cancer.’ (7: p. 481).

12. I do not mean by this to suggest that recreational doping is rare or unimportant. It clearly is a matter of serious concern in the West where many seek pharmacological enhancement of their physicality in order to achieve greater social capital that goes along with a muscle bound appearance (7; 45).


14. In holding this position I take it that I am in agreement with Russell (43) who criticizes of DADs (danger averting devices) because of their attempt to eliminate all physical risks from childhood leaving them thus unprepared for the risks that will surely attend their adult lives. This criticism does not extend to pediatric doping.

15. There are exceptions to be noted. In Italy, for example, preparticipation heart screening is compulsory for those engaging in sports. Moreover, all professional boxers have mandatory brain scans.

16. I am also mindful that the incompetence argument was attempted in defense of Ben Johnson at the Dubin inquiry. It was argued, unsuccessfully, that his powers of autonomy were sufficiently etiolated (in addition to the fact that his relationship with his training entourage so manipulative) served to reinforce his heteronomy.

17. Though I grant that the age of 18 which is typically taken for legal majority is arbitrary as is the boundaries of the concept of childhood is (see 4).

18. It is of course true that no time slice can be replaced once past. Nevertheless, the time of life which is the object of this discussion is particularly valuable owing in part to maturational issues of a biological and psychological kind. In these years significant harms may attend drug use as has been witnessed in the East German state sponsored scenario noted above.

19. The Fraser guidelines are issued to UK doctors in scenarios such as pediatric consent to contraception in the absence of parental or proxy consent: (i) the young person will understand the professional’s advice; (ii) the young person cannot be persuaded to inform their parents; (iii) the young person is likely to begin, or to continue having, sexual intercourse with or without contraceptive treatment; (iv) unless the young person receives contraceptive treatment, their physical or mental health, or both, are likely to suffer; and (v) the young person’s best interests require them to receive contraceptive advice or treatment with or without parental consent.

20. There is some dispute as to whether this appellation is sufficiently accurate for it to persist as common currency (57).

21. This too has been my experience in conducting ongoing focus groups and interviews with over 80 elite 16–21 year old athletes in the UK (41 unpublished; 42 unpublished).

22. The others being that the substance is performance enhancing and against the spirit of sport. The code adopts a policy of banning where at least two of the three criteria are met (or where a masking agent has been used to avoid detection of a product or substance under that rule).

23. Notwithstanding this generalization it is necessary to note that very considerable disquiet has been registered by political and religious communities about the validity and reliability of the statistics on mortality rates in abortive surgery. This would need to be borne in mind if com-
paring doping with more serious medical interventions.

24. For example, one study of high school American football players found students starting even earlier, the average age of first time users 14 years. More alarmingly, 15 per cent of the athletes began taking AAS before they were aged 10 (51).

25. I develop this point in the context of risky activities in McNamee (37).

26. As I have indicated above, the statistics bear out the masculine reference.

27. See, for example, Gregory and Fitch (25).

28. I record my gratitude to Andrew Bloodworth, Steve Edwards and Verner Møller for the helpful comments on earlier drafts, and also to the anonymous reviewers and Editor of the Journal.

References


