Written evidence submitted by Dr Richard Freeman MChB MRCGP MSc FFSEM (BDA0018)

Dear Mr Collins.

Thank you for asking me to contribute to your inquiry "Combatting doping in Sport".

I will endeavour to provide written answers to the requests that your committee has made to me to the best of my present ability, subject to my professional duties regarding patient confidentiality.

I shall do this by answering in sections which I hope will answer your questions which I have included in Appendix 1 for reference.

Introduction.

As a doctor the health and welfare of my patients will always be my overriding concern.

I presently practice as a specialist in sport and exercise medicine, and was revalidated by the General Medical Council to do so in 2016. I presently work as the team doctor to the Great British Cycling Team, providing 4 days per week for that care. Previously, from 2009-2015, I worked as Team Doctor for both British Cycling and Team Sky.

I qualified in 1984 and have previously worked as a junior hospital doctor, a general practitioner, and a musculoskeletal physician.

In anything I say, including this statement, I must be mindful of my duty of confidence towards my patients and I hope you can understand that.

Trust between the patients and their doctor is essential in this process and is reflected in the fundamental privilege of doctor/patient confidentiality. I believe patients have a right to expect this to be maintained by their doctors, even if at personal cost to the doctor. Indeed the public need to see this relationship being maintained, which I have done and will continue to do so, and will influence the content of this response to you.

I also hope that my patients know that I always put their health first, and have a holistic and long term, as well as short term, management strategy for their health. Whenever I can I practice with the best evidence based medicine available to me, will integrate my patient's own preferences and, involve them and their coaches in decision making related to their care. I also aim to give a clear explanation of the risks and benefits of proposed treatment and to try to improve my understanding the physical and psychological demands of their chosen sport, in order to work with them to achieve their performance goals.

I have always believed in due process and I welcomed the decision by UKAD to investigate an allegation of wrong doing in sport at the end of the Dauphine 2011. I respect the UKAD's contribution to clean sport in the UK and have fully co-operated with their investigation. UKAD have asked me to maintain absolute confidentiality with all aspects of their investigation.

Role of the doctor in sports medicine

In my introduction I began to explain this role, it is to integrate good medical management of the patient with the coaching demands on the athlete, the athlete/coach/doctor working in synergy to a common goal accountable to a performance director and ultimately a board.

These are the unique challenges of practising elite sports medicine. Professional athletes rarely train or compete without illness and injury just before, during or after competition. The motivation to do this, may simply be a fact of life that their sport is their profession, or by their own motivation, the demands of their coach, team or even organisation. Doctors continuously assess and manage their health status, including strategies to reduce the risk of illness or injury, with the expert support of a multi-disciplinary team including physiotherapists, soft tissue therapists, psychologists, nutritionalists, biomechanists, podiatrists, strength and conditioning coaches and others. The doctors' role is to co-ordinate all this support, effectively risk managing their patient's health with their informed consent in partnership with their coach.

In this model of care crucial and complex treatment issues, including return to play decisions are the ultimate responsibility of the doctor.

My practice has never been compromised by coaches or management ever at Team Sky or British Cycling.

That is not to say there aren't tensions and conflict of opinions at times but I can state that in my opinion, athletes health has never been compromised by forcing me to make a recommendation against my will and clinical judgment.

I have never encountered a winning at all costs attitude in these organisations. Indeed both organisations have indeed allowed me to care for my patients protecting me from the performance demands that exist to win in elite sport.

Elite sport is coach led and the involvement and integration of the medical and coaching teams is essential. This requires the patient/athlete to have the trust and confidence in the coach to share in their medical information as appropriate. This allows the coach to enter the confidential environment of the doctor/patient relationship, which is unique and crucial to managing elite athletes and to optimise their performance. The coach has to respect the confidentiality of this relationship and recognise the importance of it. This communication and working practice exists at both Team Sky and British Cycling, and I acknowledge the patient/athlete and coaches co-operation to allow this to happen. There have been many times when the working relationship between doctor and coach has been tested to the limit and has been perhaps my greatest challenge to the model of my medical care. Without the ability to work with even the most demanding of coaches, I don't think I could work so effectively as the team doctor in both teams particularly as I was the doctor dealing with the most challenging decisions in both teams.

Record Keeping

In 2010 I inherited a paper based record system at British Cycling and as Team Sky was a brand new team both Dr Peters, as clinical director and psychiatrist and myself as lead clinician chose to keep the majority of our patient records on our laptops. Travelling with a team is a very different

environment to sitting in a GP surgery. I did not have my usual practice of having a medical secretary. Processes of medical record keeping however were evolving rapidly in 2011 and continued to do so including the development of operating policies, although at that time they were a work in progress.

In 2010 a team support member died on the Vuelta a Espana. The evolving clinical situation was not made apparent to either Dr Peters or myself until shortly before our colleague died.

As a direct result of that, in 2011 Dr Peters as clinical director and myself as the lead doctor for 7 other part time race doctors in Team Sky decided that we needed a better means of in/post race communication and that's why the Dropbox process (which was already used by Team Sky for general information sharing) was adapted to allow medical information to be shared. It was never meant to replace individual doctors' medical records (although ultimately this occurred).

Race doctors were encouraged to contact myself directly by phone re significant issues during a race or those riders needing follow up post-race. Dr Peters chaired a fortnightly telephone conference for all the medical team at which every individual riders' health was discussed. A similar but face to face clinical case conference called the Rider Development Team meeting occurred at the velodrome for the British Cycling team riders on a fortnightly basis too, for all the support staff including clinical staff. Accordingly, I primarily relied on my own note keeping. I did not routinely upload these notes to Dropbox which I found difficult to use, having ongoing concerns about its security and greater confidence in my own system of note keeping.

Today in 2017 both teams use commercial secure and backed up record keeping systems which I think has been a significant and beneficial evolution. The primary purpose of this new medical record system is to facilitate good medical care, but it will also assist investigations into alleged wrong doing, if such concerns are raised in the future.

In 2011 neither team had a written medicines management policy or stock taking system. This was not uncommon practice in sports teams at that time. In early 2012 Dr Peters and I introduced a basic stock control review of the medicines ordered for British Cycling.

This has evolved into a written medicine management policy and I shall include the British Cycling Medicines Management Policy as Appendix 2 for your information. In 2011 medicines both prescription and over the counter medicines were ordered in bulk then dispensed to individual patients and this process recorded in their medical records. This included not just the name of the medicine but the dose recommendations, the amount and the batch number, to minimise the risk of medicines containing prohibited substances being acquired by a rider. This was supplemented by writing prescriptions for patients to obtain medication from off-site pharmacies.

The present system of medical record keeping and medicines management is a massive improvement to that which existed in 2011. I accept that it would have been desirable to have backed up my clinical records, whatever system was used. I regret not doing this. In 2011 both Team Sky and British Cycling medical teams were providing excellent clinical care with a large work load and, there were governance processes in place but with areas for improvement.

The Dauphine 2011

Team Sky like all sports teams try to be self-sufficient when travelling. Their medical teams are no different, and especially with regard to medication supply we have all have learnt from the Alain Baxter situation in about 2002 (where an athlete bought and administered a medicine from a foreign pharmacy, which was found to be an anti-doping violation) when obtaining medicines overseas. It was very important to be sure that any medicines sent to the team on tour were appropriate and from a reliable source (i.e. we frequently ordered medicines to be sent from our UK wholesale supplier to Europe). It is important to note in 2011 that Fluimucil was only provided by 1 overseas supplier (mainly), and obtaining further supplies from them whilst on tour was very impractical, particularly when we had stock remaining in store.

For all doctors it is always difficult to know how much medicines and wound dressings to take, especially in a cycling stage race lasting a week, with riders with varied individual health needs. Staff health is also the responsibility of the travelling doctor.

The Dauphine in 2011 was also unique for me, as a high altitude training camp followed immediately after the race without the opportunity to return to my place of work to re-stock. I wanted to ensure I had enough supplies of medication if required at that training camp, having used up some of my present stock during the race.

There is immense time pressure on the team members, riders and staff. All staff have their own demanding role, no-one is the doctor's assistant. The doctor's day usually starts at 6 am with a rider doping control, often having been disturbed in the night to attend to illness or the symptoms of recent injury. There's a daily ward round of all the riders, also any staff requiring medical help, wound dressing changes, urine osmolality/weights to check, supervision that breakfast/nutrition/hydration is satisfactory, packing up, then travelling to the next stage start. I found this daunting but manageable. Doctors could rarely leave the team for any more than a few minutes they are always on duty for the care of the riders and staff and to supervise the unannounced doping control tests. The next part of the day is taken up with then following the race in the team car ready for illnesses and injuries. Then there is the travel from race finish to hotel, then care of riders health needs coordinating other support staff, dinner, team management/coach/director sport if meetings and a final before bed ward round of riders

My request made to Shane Sutton a day or two before the end of the Dauphine 2011 was set against this background. I do not believe Fluimucil nebuliser solution was then available in France, by contrast to the powder version to be made up with water as a drink for oral ingestion, which I do not believe to be particularly effective.

In April 2011, during the Tour de Romandie in Switzerland, I purchased Fluimucil nebuliser solution from Pharmacie De La Plaine, in Yverdon (where the team stayed for 3 consecutive nights). I have not brought any medication from the pharmacy before or since. During the Dauphine in June 2011, we were running low on Fluimucil during the Dauphine, my first thought was of the supply I had in Manchester, and that the Team would be able to access that supply quickly. It did not occur to me to travel to Switzerland.

Only Fluimucil was contained in the package sent.

The use of this medication by nebuliser, is believed by many doctors to be mucolytic, which is helpful in managing stage riders, who as they compete in adverse weather, at high altitudes for 5-6 hours per day are prone to chestiness and excess respiratory mucus production. As with all medication, there is a risk/ benefit ratio to consider, patients preferences and individual patients previous experience/benefit before prescribing. For the committees' benefit it usual practice to administer nebulised Fluimucil after and not before racing due to possible unwanted immediate side effects on airway reactivity (asthma). I am not able to speak about specific patient treatments without a patient's consent.

Medicines and the WADA code.

The WADA code is one of the foundations that allow athletes to compete in a performance-enhancing drug free environment.

WADA defines the regulations and processes to facilitate this and I'm fully committed to their principles.

The prohibited substances list is comprehensive and is constantly evolving.

The International Standard of Therapeutic Use Exemption is integral to this process. This allows athletes access to good medical care when there is medical need.

The ISTUE has robust criteria to meet, crucially that the medicine is not performing enhancing. It is a very transparent process the National Anti-doping Organisation (UKAD), International Federation (UCI) and WADA being able to view it or challenge it. TUE committee members are experts and base their decisions on evidence based medicine.

The TUE process is a confidential process made by an athlete, with supporting evidence of medical need by a team doctor historically, usually if not always, supplemented with external expert medical opinion. The medical practice as I have described is practised in Team Sky and British Cycling allows for individual patient confidentiality, patient preference, coach and performance director involvement. I am not, and have not been concerned that the TUE process is abused by athletes, in relation to my clinical experience and practice.

Medicines are always prescribed for clinical need. Triamcinolone is an anti-inflammatory glucocorticoid steroid injection in frequent use in medical practice for a variety of medical conditions. There are infrequent occasions when there is a clinical need for its use in elite sport to allow return to train or compete and there are clear WADA guidelines on its administration. Once again I must stress that this is based in clinical need and within the model of health care delivery that I have described at Team Sky and British Cycling.

I have only ever personally administered triamcinolone to one rider at Team Sky and British Cycling. In the last 7 years I'm aware of only a handful of riders in either team being referred to hospital for image guided triamcinolone injection for clinical need, with none needing a TUE. Coaches and Performance Directors were involved in the process. The ethics of this treatment was discussed. No concerns were raised with me about this treatment. Use of triamcinolone is very infrequent in these teams but my obligation to doctor/patient confidentiality does not allow me to explain further.

Tramadol has always been used infrequently in Team Sky and only ever according to clinical need. No one has ever raised concerns regarding its usage at Team Sky with myself. Records of use were kept on individual patient records.

The present Medicine Management Policy allows for travelling with medication that is stock controlled. It requires all such medication to be ordered from suppliers holding a Wholesale Distribution Authorisation. It also demands that no stocks of medicine are kept for personal dispensing to patients at the velodrome, but require the generation of a prescription to be taken by the patient to a pharmacy. This prescription is generated in and recorded within the secure backed up medical record keeping system in routine use. Only a very limited stock of prescription medicine required to deal with life threatening medical emergencies are kept at the velodrome and are subject to the above MMP stock control.

Improvements to Process

Many of these are obvious and have happened with evolution, some as the direct response to the UKAD investigation.

Many of them have improved my administrative practice.

Improvements are:

External clinical governance and appraisal system for the medical department.

Electronic, secure, backed up medical records system.

Written medicine management policy and medicines stock control process.

Ordering of medicines only via holders of a Wholesale Distribution Licence

British Cycling registration for inspection by the Care Quality Commission

Finally, it is imperative to continue the philosophy that exists in Team Sky and British Cycling for zero tolerance to doping.

Their riders want this reputation, and these organisations have delivered it in the past and will attempt to do so in the future.

I'm immensely proud to have been able to provide support to these athletes. I believe the clinical governance and appraisal in place at both Team Sky and British Cycling is now appropriate for this task.

These athletes' achievements have not only entertained a nation and inspired a generation of future Olympians, but also very importantly introduced enjoyable physical activity to millions. "Get on your bike" now has a very different association to how it was used in the past. I sincerely hope this massive public health and happiness benefit from riding bikes continues.

I admire not simply the talent of these riders, but their determination to succeed by their own blood sweat and tears and acknowledge particularly in more recent times, the widely publicised recent culture at British Cycling hasn't made this easy. British Cycling lost an exceptional performance

director in 2014 (when Sir David Brailsford went to Team Sky full time), who had created a tough but fair performance driven environment, Dr Steve Peters who had been the balance and check to ensure fair and functioning inter-personal relationships within the GB cycling team also departed, and his influence was also greatly missed. I await the due process with the publication of the independent UK Sport inquiry.

I hope with a new performance director, a new chief executive, a new chairman and an adequately resourced compliance department, that British Cycling can function effectively (including in relation to anti-doping compliance) so that the future of the riders at BC will be a fair and successful one, and in which the British public can have confidence rightly restored.

Appendix 1

The CSM chair and committee have requested answers to questions sent to me 4 occasions and these are in order of receipt as follows

1.

The lines of questioning are likely to focus on the process of providing drugs to professional cyclists: the use of drugs, the role of the doctor (does s/he, for example, provide non-prescription as well as prescription drugs), the relationship between doctors and coaches in ensuring athlete health and fitness, the keeping of records by the doctor, the use of prescriptions, whether the 'medicine cabinets' of sports teams or sports governing bodies are subject to the same sort of controls and requirements for retention of records as ordinary pharmacies, how potentially performance-enhancing drugs are policed.

2.

1. What is the role of the doctor in maintaining the health of professional athletes? Presumably, you have to be in control of all aspects of an athlete's health: what medical interventions there are, including non-prescription as well as prescription drugs, controlling processes out of and in competition.

2. What is the relationship between doctor and coach in supporting a professional athlete? Do you have to keep each other informed about everything the athlete is doing?

3. What is the usual process for administering prescription drugs to athletes? Does the doctor have to write a prescription in the normal way? Does the pharmacy have to keep records of what is dispensed?

4. How is the use of corticosteroids and other performance-enhancing drugs policed outside competition? Who runs the process?

5. Are you concerned that TUEs are being abused by athletes?

6. How could the process be improved to avoid the kind of difficulties that have been experienced by Team Sky, British Cycling and Sir Bradley over the 'jiffy bag' incident?

7. Should more be done by British Cycling to police doping within the sport?

3.

When did you ask Shane Sutton if a medical package could be brought out from Manchester to La Toussuire for the end of the 2011 Criterium du Dauphine?

Other than fluimucil, was there anything else in the package that was delivered to you by Simon Cope, at the Criterium du Dauphine on 12th June 2011? If so, can you say what it was?

Could you confirm from which pharmacy in Switzerland you had obtained fluimucil on behalf of Team Sky in 2011, prior to 12 June that year? Why also didn't you order the fluimucil from your supplier in Switzerland in June 2011, rather than having it brought out from Manchester?

If Sir Bradley Wiggin's required medical treatment with fluimucil during the 2011 Criterium du Dauphine, why did you wait until after the race to administer it?

The date given by the UCI for the application for Bradley Wiggin's 2011 TUE was 30th May, is that date correct? If so, why was there such a long delay between the application for the TUE and it being granted?

Why was it that from June 2011 until the disappearance of your laptop in 2014, you didn't upload copies of medical records for Sir Bradley Wiggins, relating to the treatment you administered to him on 12th June 2011, to the Team Sky dropbox folder, in line with Team Sky policy at the time? Why also didn't you keep any other back up of the medical records from this time?

Why didn't you have prescription rights in France in 2011, given the amount of time you would have spent with Team Sky at important cycling events in that country during that year? Was it common for Team Sky doctors not to have prescription rights in France?

How many ampoules of triamcinolone were administered to Team Sky riders between 2010 and 2013, and how many Team Sky riders received this treatment?

Who else in the management of Team Sky was aware that triamcinolone was being used by riders out of competition? Was there ever any discussion about this ethics of this treatment?

Did anyone at Team Sky or British Cycling ever raise concerns with you about the treatment of riders in the team with triamcinolone?

How frequently was tramadol given to Team Sky riders? Did you keep records of its usage? Did anyone ever raise concerns with you about the usage of tramadol at Team Sky?

4.

One thing that would be very helpful for the committee as we consider our report, would be your insight on the general relationship within a team like Team Sky, between the doctors, riders, coaches and management. From the evidence we have received so far, the impression that has been created is that the doctors determine the treatments required by the riders, with very little discussion or

input from the coaching staff. I do wonder though whether this is a fair representation of the dynamics within the team.

March 2017