

Application No. 10934/21

IN THE EUROPEAN COURT OF HUMAN RIGHTS

BETWEEN

Semenya,

Applicant

– and –

Switzerland,

Respondent

**SUBMISSIONS ON BEHALF OF THE WORLD MEDICAL ASSOCIATION
AND
THE GLOBAL HEALTH JUSTICE PARTNERSHIP**

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INTRODUCTION

1. These written submissions are made by the World Medical Association and the Global Health Justice Partnership pursuant to article 36 § 2 of the Convention for the Protection of Human Rights and Fundamental Freedoms (the European Convention on Human Rights, ECHR) following leave granted by letter dated 31 August 2021 by the President of the Section under rule 44 § 3 of the Rules of the Court.
2. The World Medical Association (WMA) is a global federation of National Medical Associations representing millions of physicians worldwide. It aims to ensure the independence of physicians and the highest possible standards of ethical behavior and care by physicians toward all people. The WMA provides ethical guidance covering a wide range of subjects, including health-related human rights, in order to promote and defend the basic rights of patients and physicians. The Global Health Justice Partnership (GHJP), an initiative of Yale University's Law School and School of Public Health, was established to promote interdisciplinary, innovative, and effective responses to key risks to health-related rights globally. The GHJP works in partnership with relevant scholars and practitioners around the world to move research and analysis into action to promote the rights and health of all persons. The GHJP has developed an extensive program of research and policy analysis on gender, health, and rights.
3. The WMA has unequivocally objected to the Eligibility Regulations for the Female Classification (Athletes with Differences of Sex Development) 2019 ("Regulations") approved by World Athletics (previously the IAAF) and called on physicians to refrain from participating in their implementation. These submissions are in furtherance of the WMA's consistent position on the Regulations and seek to demonstrate that: (i) the Regulations cannot be implemented without the active participation of physicians; (ii) the Regulations engender the violation of fundamental ethical principles and obligations generally accepted in the medical community and enshrined in various Declarations of the WMA; and (iii) these principles and obligations relate to the rights guaranteed under the European Convention on Human Rights and can aid the Court in their interpretation.

THE ROLE OF PHYSICIANS IN THE IMPLEMENTATION OF THE REGULATIONS

4. The Regulations limit participation in certain track events in the women's classification based on eligibility criteria that must be identified by physicians, including blood testosterone level, androgen sensitivity, and the presence of one of certain listed "differences of sex development."¹ The Regulations require certain athletes to reduce and maintain their blood testosterone below a certain level through pharmacological or surgical interventions that must be prescribed and administered by physicians.
5. At all stages of implementation, the Regulations implicate and rely on physicians, which may include athletes' personal physicians; physicians affiliated with or appointed by World Athletics or national athletics federations; or other specialists. A combination of these medical professionals may be involved in each of the three distinct stages of assessment under the Regulations: identification, testing, and intervention.
6. Athletes are **identified** for investigation by the World Athletics Medical Manager, usually a physician, based on information received from sources including the athlete and the team doctors of the athlete's affiliated national federation. Information may include

¹ The list of DSDs covered by the Regulations are: 5 α -reductase type 2 deficiency; partial androgen insensitivity syndrome (PAIS); 17 β -hydroxysteroid dehydrogenase type 3 (17 β -HSD3) deficiency; ovotesticular DSD; any other genetic disorder involving disordered gonadal steroidogenesis.

the results of routine pre-participation health examinations and from the analysis of blood or urine samples collected for anti-doping purposes.²

7. Identification is followed by a multi-step **testing** process carried out by a range of physicians. It involves: (1) an initial clinical examination, compilation of data, and preliminary endocrine assessment carried out by qualified physicians; (2) possible further assessment by an expert panel of medical professionals convened by World Athletics; and (3) possible further assessment at a designated specialist reference center. The physicians involved may include the athlete's own physician, gynecologists, endocrinologists and pediatricians, among others.
8. If the expert panel determines that an athlete does not meet the stipulated eligibility criteria, it will specify steps the athlete could take to satisfy the eligibility conditions.³ These involve **reducing** and maintaining the athlete's natural blood testosterone level below the specified level through pharmacological or surgical interventions.
9. In sum, the Regulations depend on the active participation of physicians – across specialties – at every stage of implementation. It is therefore of critical concern that such implementation entails the violation of the ethical principles and obligations most fundamental to the medical profession.

VIOLATION OF THE PRINCIPLES OF MEDICAL ETHICS

10. Crucially, throughout the steps in the process stipulated by the Regulations, athletes do not voluntarily come to physicians as individuals seeking medical care. Rather, they are compelled to appear before physicians for the sole purpose of athletics' eligibility rules compliance.⁴ Therefore, the patient-physician relationship is tainted from the outset by external coercion. This creates an indefensible situation in which physicians are faced with "patients" who have not freely sought nor require care. Nonetheless, physicians have ethical obligations to the athlete-patients now before them, ethics that the Regulations ask them to violate.
11. The WMA recognizes the following medical ethics principles as core values of the medical profession: respect for autonomy, beneficence, non-maleficence, and justice, as well as confidentiality, non-discrimination, consciousness, and the defense of human rights.⁵ These principles underpin the codes of many regional medical associations, including the American Medical Association,⁶ the Africa Medical Association,⁷ and the Conseil Européen des Ordres des Médecins.⁸ Further, the WMA's Declaration of Geneva

² Eligibility Regulations for the Female Classification (Athletes with Differences of Sex Development) 2019 ("Regulations"), r 3.2, 3.3.

³ Regulations, r 3.9.

⁴ Regulations, r 3.5.

⁵ Declaration of Geneva [1948] <<https://www.wma.net/policies-post/wma-declaration-of-geneva/>> accessed 4 October 2021. Declaration of Lisbon on the Rights of the Patient [1981] <<https://www.wma.net/policies-post/wma-declaration-of-lisbon-on-the-rights-of-the-patient/>> accessed 4 October 2021. Declaration of Cordoba on Patient-Physician Relationship [2020] <<https://www.wma.net/policies-post/wma-declaration-of-cordoba-on-patient-physician-relationship/>> accessed 4 October 2021. Declaration of Helsinki – Ethical Principles For Medical Research Involving Human Subjects [1964] <<https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>> accessed 6 October 2021.

⁶ AMA Code of Medical Ethics [2001] <<https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf>> accessed 4 October 2021.

⁷ Proposed AfMA Statement (of Pilanesberg) on Health Information to and Communication with Patients [2006] <<https://africama.net/policies.htm>> accessed 4 October 2021.

⁸ Principles of European Medical Ethics [1987] <http://www.ceom-ecmo.eu/en/view/principles-of-european-medical-ethics>> accessed 4 October 2021.

– the modern Hippocratic oath – dictates that physicians will not, in any circumstances, use their medical knowledge to violate human rights and civil liberties.⁹ Any medical assessment or intervention that does not privilege the patient’s health and well-being, and that is conducted without their free and informed consent, is in opposition to the fundamental medical ethics principles reflected in the WMA’s statements.

a. Respect for autonomy

12. The WMA has made strong commitments to the ethical principles promoting both patient and professional autonomy. First, the WMA’s Declaration of Seoul on Professional Autonomy and Clinical Independence stipulates that physicians must have the freedom to exercise their professional judgment in the care and treatment of their patients without undue or inappropriate influence by outside parties.¹⁰ The Regulations, however, ask physicians not only to identify, examine, and diagnose at the behest of an entity other than the patient (as may arise in workers’ compensation systems or employment fitness protocols for pilots, e.g., and which may also raise ethical concerns),¹¹ but also to *intervene* upon athletes using non-beneficial practices aimed at compliance with sports regulations, rather than making therapeutic and clinically appropriate recommendations. Efforts to bring athletes into compliance with the Regulations reveal external influences on professional autonomy, jeopardizing the patient-physician relationship.
13. The WMA’s Declaration of Geneva requires physicians to respect the autonomy and dignity of their patients, strongly focusing on confidentiality and consent.¹² These principles have been further translated into discrete rights in the WMA Declaration of Lisbon on the Rights of Patients: (i) the right to choose freely one’s physician and health service institution; (ii) the right to self-determination, to make free decisions regarding oneself, and to give and withhold consent to any diagnostic or therapeutic procedure; and (iii) the right to confidentiality of one’s health status, medical condition, diagnosis, prognosis, treatment, and all other information, even after death, except with explicit consent from the patient or as provided by law. Procedures without patient consent may be carried out only in exceptional cases, specifically permitted by law and conforming to medical ethics. Yet, the Regulations ask physicians to ignore their obligations to their patients, engendering practices that deny the ability of athletes/patients to make informed decisions and exercise moral choice.
14. For example, while the Regulations state that “no athlete will be forced” to submit to medical assessment or interventions, the consequence of such refusal is exclusion from the event(s) in which the athlete specializes.¹³ Facing a set of forced choices does not allow athletes to make a truly voluntary decision about whether to undergo the assessment or intervention. From the perspective of medical ethics, the conditions required for the informed consent of the patient are not met, especially in light of the elements of coercion. Particularly coercive conditions arise where athletes, their families, as well as the national federations and the team of agents, promoters, and sponsors supporting them, depend on their sporting career for their livelihood and economic stability. This has been shown to

⁹ Declaration of Geneva, n 5.

¹⁰ Declaration of Seoul on Professional Autonomy and Clinical Independence [2018] <<https://www.wma.net/policies-post/wma-declaration-of-seoul-on-professional-autonomy-and-clinical-independence/>> accessed 4 October 2021.

¹¹ International Dual-Loyalty Working Group, Dual Loyalty & Human Rights in Health Professional Practice: Proposed Guidelines & Institutional Mechanisms [2003] 48 <<https://phr.org/our-work/resources/dual-loyalty-and-human-rights-in-health-professional-practice/>> accessed 6 October 2021.

¹² Declaration of Geneva, n 5.

¹³ Regulations, r 2.5, 2.6.

be the case insofar as the Regulations disproportionately affect athletes from under-resourced nations.¹⁴

15. In prescribing and carrying out the medical interventions to meet the eligibility criteria in the Regulations, physicians are faced with a stark dilemma: either they act against the core values of their profession or oppose the Regulations' imperatives and risk losing their work. This is also true of physicians employed by national federations who are in turn bound by World Athletics' rules and regulations (i.e., a "multiple principal problem," also sometimes framed as "dual loyalty" in medical contexts).¹⁵
16. The Regulations therefore put physicians at risk of violating key medical ethics principles derived from autonomy. For example, ethical principles protecting informed consent require that a patient or their authorized representatives be provided with complete information about their medical condition, treatment options available, associated benefits and risks in the immediate and long-term, and anticipated costs, in language they understand.¹⁶ Yet, in facilitating compliance with the Regulations, physicians are required to focus on specific non-health related goals such as lowering testosterone to a certain level, rather than presenting all options, including no interventions at all. Such a narrow lens creates risks that athletes will not receive or fully consider all information on the tests and procedures to be conducted, or the implications of test results.¹⁷
17. Further, the Regulations operate to put physicians at risk of conduct that violates confidentiality obligations toward their patients. This risk may arise either directly (through the provision of medical information such as test results to athletics authorities, including World Athletics, or national athletics federations);¹⁸ or indirectly, (by implicating physicians in chains of information sharing in which athletics authorities, who have shown themselves not to be reliable in terms of confidentiality, act in ways that result in an athlete being disqualified or changing events, making it obvious that an athlete is suspected of having a difference of sex development).¹⁹
18. The coercive nature of the entire process is reinforced by the involvement of physicians associated with national federations. While the procedures and processes set out in the Regulations reflect and govern only World Athletics' approach and action regarding eligibility testing, they call for the cooperation and support of the national federations in their application and enforcement.²⁰ This introduces an additional layer of opacity and a cascade of abusive interventions, as the Regulations' trickle-down effects are seen in efforts by national federations, through their team doctors and affiliated physicians, which proactively monitor and test athletes for signs of differences in sex development. For instance, clause 3.3 specifically identifies team doctors of national federations as "reliable sources of information." Athletes subjected to monitoring, invasive check-ups and testing have recounted instances where a variety of interventions and tests were conducted in quick succession, and where they were not provided sufficient information

¹⁴ See Human Rights Watch, 'They're Chasing Us Away From Sport – Human Rights Violations in Sex Testing of Elite Women Athletes' [2020] 58, 93-97 <<https://www.hrw.org/report/2020/12/04/theyre-chasing-us-away-sport/human-rights-violations-sex-testing-elite-women>> accessed 4 October 2021.

¹⁵ *ibid* 54-56.

¹⁶ Varkey B, 'Principles of Clinical Ethics and Their Application to Practice' [2020] *Med Principles and Practice* 17, 29.

¹⁷ Human Rights Watch, n 14 at 63-67.

¹⁸ Human Rights Watch, n 14 at 59, 61-63.

¹⁹ Human Rights Watch, n 14 at 46, 59, 65.

²⁰ Regulations, r 1.3.

or detail on the process or results.²¹ Athletes have also spoken of being pressured by physicians affiliated with national federations to undergo invasive physical examinations of chest and genitals leading to medically unnecessary interventions so they could continue to compete.²²

b. Beneficence and Non-maleficence

19. The principle of beneficence obliges physicians to act in a way that benefits the patient, including to promote their overall welfare by balancing the benefits of any intervention against risks and costs. Relatedly, the principle of non-maleficence obliges physicians to avoid causing harm to the patient, including unnecessary pain, suffering, or offense.²³
20. The principles of beneficence and non-maleficence are at the heart of the patient-physician relationship. The WMA's Declaration of Cordoba on Patient-Physician Relationship highlights that the privileged bond between patient and physician is "the fundamental core of medical practice" and is based on trust arising from the physician's commitment to alleviate suffering and improve a person's health and well-being.
21. The Regulations ask physicians to prescribe and administer medical interventions for the purpose of compliance with sports eligibility rules regardless of whether this is in the best interests of the patient and will benefit their health and well-being. A medical intervention is, in general, only appropriate where there is a medical need; medically unnecessary interventions are generally not in the best interests of patients and can lead to long-term and even unanticipated health consequences.²⁴ All procedures to reduce blood testosterone for the purpose of compliance with the Regulations, as opposed to a health-related reason, are inherently medically unnecessary, a fact that physicians connected with World Athletics have acknowledged.²⁵ They cannot, therefore, be said to be in the individual's benefit or in accordance with the beneficence principle.
22. Moreover, all such procedures have potential side effects, which constitute risks that cannot be balanced against any health benefit because, again, their purpose is compliance with sports eligibility rules. These side effects include diuretic effects that cause excessive thirst and urination, electrolyte imbalance, liver toxicity, disruption of metabolism, inhibited steroid production, cortisol deficiency, headache, fatigue and nausea (in the case of pharmacological interventions such as hormonal contraceptives or GnRH contraceptives),²⁶ as well as compromised bone strength, chronic weakness, depression, diabetes, and sterilization (in the case of surgical interventions such as

²¹ Human Rights Watch, n 14 at 63-67.

²² Human Rights Watch, n 14 at 59.

²³ Principles of Biomedical Ethics, n 5.

²⁴ Medical interventions do not always take place only in case of a medical need, for instance where certain testing is ordered by a judicial body or for purely aesthetic reasons. However, in these cases, such interventions are either required by law or take place with the free and informed consent of the patient, which are distinct from the kind of interventions required under the Regulations, which are (a) not binding law enacted by a State and (b) under which athletes must either agree to reduce their blood testosterone levels in order to continue participating in the athletic events covered by the Regulations or risk being excluded.

²⁵ The lack of any medical condition requiring surgical and pharmacological interventions on athletes has been acknowledged by sports officials affiliated with World Athletics in a retrospective clinical study they conducted on athletes on whom partial clitoral removal with bilateral gonadectomy were performed. See Patrick Fenichel et al, 'Molecular Diagnosis of 5 α -Reductase Deficiency in 4 Elite Young Female Athletes Through Hormonal Screening for Hyperandrogenism' [2013] Vol 98(6) Journal of Clinical Endocrinological Metabolism E1055, E1057.

²⁶ Human Rights Watch, n 14 at 63-67, 82, Rebecca Jordan Young et al, 'Sex, Health and Athletes' [2014] BMJ 348, 349.

gonadectomy).²⁷ Causing these harms to an individual, without a health or well-being related reason to justify them, offends the non-maleficence principle.

23. Importantly, the principles of beneficence and non-maleficence require recognition that what constitutes a benefit for one patient may be harmful to another.²⁸ Thus, while some women choose to take oral contraceptives for birth control or regularizing their menstrual cycle, the objectives of such interventions relate to their own fertility and other health goals and are markedly different from reducing blood testosterone levels to meet sports eligibility standards. Likewise, while individuals with differences in sex development may sometimes choose to undergo interventions like surgery to address specific medical needs such as the prevention of a germ cell tumor, this is not the case with athletes investigated under the Regulations. These athletes have not indicated any health concern and indeed, having a blood testosterone level above 5 nmol/L (or any other limit) is not in itself considered a medical condition requiring treatment.²⁹
24. The Regulations ask physicians to act contrary to their ethical obligations by disregarding the range of risks associated with reducing blood testosterone level and by prescribing and administering interventions even in the absence of any medical need or health benefit. For this reason, the WMA has called on physicians to oppose the Regulations and refrain from implementing them on the ground that “[i]t is in general considered unethical for physicians to prescribe treatment for excessive endogenous testosterone if the condition is not recognized as pathological.”³⁰
25. Furthermore, the Regulations ask physicians to violate the rights of every patient – codified in the WMA Declaration of Lisbon on the Rights of Patients – to be cared for by a physician who is free to make clinical and ethical judgments and to always be treated in accordance with their best interests and generally approved medical principles. The WMA has recently reaffirmed its firm opposition to any forms of intrusion in the practice of medicine: the patient-physician relationship “should never be subject to undue administrative, economic, or political interferences” or any other influences that risk alienating physicians from their patients and potentially harming them.³¹ The actions taken under the Regulations, which are ongoing, compelled, non-therapeutic, and potentially harmful, undermine the essential “atmosphere of trust” in the patient-physician relationship. For these reasons the WMA has consistently opposed the Regulations and asked physicians to “refuse to perform any test or administer any treatment or medicine not in accordance with medical ethics, and which might be harmful to the athlete using it, especially artificially modifying constituents, biochemistry or endogenous testosterone.”³² Upholding these patient rights and the principles of

²⁷ Letter from Special Rapporteur on the right to enjoyment of the highest attainable standard of physical and mental health et al to IAAF (18 September 2018) <https://www.ohchr.org/Documents/Issues/Health/Letter_IAAF_Sept2018.pdf> accessed 4 October 2021.

²⁸ Raanan Gillon, ‘Medical ethics: four principles plus attention to scope’ [1994] Vol. 309 BMJ 184, 185 <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2540719/pdf/bmj00449-0050.pdf>> accessed 4 October 2021.

²⁹ See American Association of Clinical Endocrinologists, ‘Medical Guidelines for Clinical Practice for the Diagnosis and Treatment of Hyperandrogenic Disorders’ [2001] Vol. 7(2) Endocrine Practice <[https://www.endocrinepractice.org/article/S1530-891X\(20\)41140-1/pdf](https://www.endocrinepractice.org/article/S1530-891X(20)41140-1/pdf)> accessed 4 October 2021; Rebecca Jordan Young et al, n 27 at 349.

³⁰ ‘WMA urges physicians not to implement IAAF Rules on classifying women athletes’ (WMA, 25 April 2019) <<https://www.wma.net/news-post/wma-urges-physicians-not-to-implement-iaaf-rules-on-classifying-women-athletes/>> accessed 4 October 2021.

³¹ Declaration of Cordoba on Patient-Physician Relationship, n 5.

³² WMA urges physicians not to implement IAAF Rules on classifying women athletes, n 30.

beneficence and non-maleficence are fundamental obligations of physicians and are seriously interfered with by the Regulations.

c. Justice and Non-discrimination

26. Justice as a principle of medical ethics is concerned with the “fair, equitable, and appropriate” treatment of persons, including distributively just and non-discriminatory treatment.³³ Discrimination involves a failure to provide healthcare, in accordance with the other principles of medical ethics, based on a person’s individual or social characteristics such as sex, gender, race, religion, age, type of illness or economic status.³⁴ In the WMA’s Declaration of Geneva, the physician’s pledge recognizes this principle of justice by requiring physicians not to permit considerations such as age, disease, disability, ethnic origin, nationality, gender, sexual orientation or social standing to come in the way of their duty to their patients.³⁵ This duty of physicians relates to the right of patients to appropriate medical care without discrimination.³⁶
27. To understand how the Regulations implicate physicians in discriminatory practices, it is useful to attend to the characteristics one by one. *First*, the Regulations only apply to women and involve the surveillance of all women, especially those whose gender presentation does not match dominant stereotypes of femininity. As noted by United Nations human rights experts, the Regulations’ surveillance of all women, and the selection of a subset of women to investigate, reinforces negative stereotypes and stigma around race, sex, and gender identity and subjective expectations around which bodies are appropriate.³⁷
28. *Second*, the Regulations are only concerned with the eligibility of women with a specific set of intersex variations or differences in sex development known as 46,XY DSD, characterized by the Regulations as blood testosterone level above 5 nmol/L and “sufficient androgen insensitivity for those levels of testosterone to have a material androgenizing effect.”³⁸ In practice, assessment is made through reference to the supposed material androgenizing effects on physiological traits like breast development, body hair, and clitoral size that are determined through invasive and offensive exams carried out by physicians.³⁹ For instance, there is evidence that athletes already under suspicion are vulnerable to being surveilled and observed for differences in their genitalia, while submitting samples for anti-doping purposes.⁴⁰

³³ Varkey B, n 16.

³⁴ Mohammadjavad Hosseinabadi-Farahani et al, ‘Justice and unintentional discrimination in healthcare: A qualitative content analysis’ [2021] <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8057166/>> 4 October 2021.

³⁵ Declaration of Geneva, n 5.

³⁶ Declaration of Lisbon, n 5.

³⁷ Letter from Special Rapporteur on the right to health, n 27.

³⁸ Regulations, r 2.2(a).

³⁹ Fabian Rose, ‘Caster Semenya and the Intersex Hypothesis’ in Sandy Montanola and Aurélie Olivesi (eds), *Gender Testing in Sport* (Routledge 2017). A prior iteration of the regulations of World Athletics in 2011 explicitly named an assortment of traits like “deep voice”, breast shrinkage, excessive body hair, clinical data on loss of menstruation over some period of time, increased muscle mass (all traits which are relatively common among elite athletes and difficult to measure) and might also encompass lack of a uterus and larger than typical clitoris. This amalgam of possible considerations contains many features which are today condemned as unacceptably culturally dependent, especially in light of greater global recognition of racial and ethnic variation within and across genders. All of these criteria however, are retained in clinical assessment guidelines used to assess material androgenizing effects pursuant to the Regulation. See Katrina Karkazis et al, ‘Out of Bounds? A Critique of the New Policies on Hyperandrogenism in Elite Female Athletes’ [2012] Vol. 12(7) *The American Journal of Bioethics*, 3.

⁴⁰ Human Rights Watch, n 14 at 83-84; Rebecca Jordan Young et al, n 30 at 349.

29. Identification and assessment efforts, including invasive questioning, have been revealed to track stereotypes around race, gender, sexuality, and conventional notions of femininity.⁴¹ Evidence suggests that athletes from the Global South are scrutinized and intervened upon disproportionately – with the assistance of medical professionals – despite identifying as women for social and legal purposes since birth.⁴² The WMA has said the Regulations “constitute a flagrant discrimination based on the genetic variation of female athletes.”⁴³
30. The Regulations’ discriminatory remit is made even more notable by virtue of the divergent regimes created for physicians according to the athletic events covered and sources of testosterone scrutinized. *First*, the Regulations only apply to women who compete in an arbitrarily chosen set of events, or a combination thereof: 400m races, 400m hurdles races, 800m races, 1500m races, one mile races, and all other track events over distances between 400m and one mile, whether run alone or in relay,⁴⁴ despite contestation around the relationship between elevated testosterone level and athletic performance.⁴⁵ *Second*, the Regulations do not focus solely on elevated testosterone levels but on the source of the testosterone (through reference to the gonadal sex) and its “masculinizing” effects (via attention directed to secondary sexual characteristics).⁴⁶ The Regulations do not apply to women with polycystic ovary syndrome (PCOS) and congenital adrenal hyperplasia (CAH), for example, who have natural testosterone levels above 5 nmol/L, but rather apply only to women with 46,XY DSD. In fact, for women with PCOS and CAH, the Regulations suggest interventions to address the risk of cardiovascular events and gynecological cancers rather than reducing blood testosterone.⁴⁷ In other words, physicians are asked to provide different advice and interventions to athletes based on the event they happen to compete in and/or the specific source of their testosterone, rather than based on health-related reasons.
31. Thus, the Regulations put physicians at risk of participating in a cascade of justice violations: identifying and intervening in women athletes’ bodies and lives under arbitrary and discriminatory gender regimes; treating two categories of women with elevated blood testosterone differently, not according to health needs but for policy compliance; and acting under dubious scientific authority in ways identified as serving a gendered and racially discriminatory goal of bringing women’s naturally occurring testosterone levels, and their primary and secondary sexual characteristics, within the bounds of what is considered acceptable for a woman.⁴⁸

⁴¹ Human Rights Watch, n 14 at 89-91; See Katrina Karkazis and Rebecca M. Jordan Young, ‘The Powers of Testosterone: Obscuring Race and Regional Bias in the Regulation of Women Athletes [2018] Vol 30(2) Feminist Formations 1.

⁴² Letter from Special Rapporteur on the right to health, n 27. Human Rights Watch, n 14 at 27. OHCHR, ‘Intersection of race and gender discrimination in sport’ [2020] 8 <<https://undocs.org/en/A/HRC/44/26>> accessed 4 October 2021.

⁴³ WMA urges physicians not to implement IAAF Rules on classifying women athletes, n 30.

⁴⁴ Regulations, r 2.2(b).

⁴⁵ Sigmund Loland, ‘Caster Semenya, athlete classification, and fair equality of opportunity in sport’ [2020] J Med Ethics 1, 4; The Powers of Testosterone, n 41 at 25, 27.

⁴⁶ See Regulations, r 2.2 (endnote 4); Silvia Camporesi and Paolo Maugeri, ‘Caster Semenya: sport, categories and the creative role of ethics’ [2010] J Medical Ethics 378, 379.

⁴⁷ Regulations, Appendix 3 point 12 (endnote 13).

⁴⁸ Letter from Special Rapporteur on the right to health, n 27.

PRINCIPLES OF MEDICAL ETHICS AND HUMAN RIGHTS

32. The right to the highest attainable standard of physical and mental health is enshrined in the International Covenant on Economic, Social and Cultural Rights. It is an inclusive right, extending beyond healthcare to the underlying determinants of health and States must abstain from enforcing discriminatory practices relating to women's health status and needs.⁴⁹ The principles of medical ethics described in these submissions support the promotion and protection of human rights in medical practice, and the WMA "is committed to promoting health-related human rights for all people worldwide."⁵⁰ The WMA has recognized that "[a] woman's right to the enjoyment of the highest standard of health must be guaranteed throughout her lifetime, equal to that of men" and "[w]omen are affected by many of the same health conditions as men, but women experience them differently due to both genetics and the social construction of gender."⁵¹
33. These principles of medical ethics correspond to ECHR rights under article 3 (right against inhuman and degrading treatment), article 8 (right to private and family life) and article 14 (right to equality and non-discrimination) and can aid this Court in interpreting these provisions in the health context.
34. This Court has previously located health rights under article 8⁵² and recognized that states have a positive obligation under articles 2 (right to life) and 8 to institute measures to protect the physical integrity of patients "...based on the need to protect patients as far as possible from possibly serious consequences of medical interventions."⁵³
35. Notably, this Court has demonstrated concern about forcible medical interventions undertaken without the consent of patients and in the absence of any therapeutic need. In *VC v Slovakia*, the Court highlighted that sterilization of a Romani woman, conducted under stereotyped and paternalistic conditions, demonstrated an absence of full, free, and informed consent, or any therapeutic objective, and generated serious consequences for the patient's physical and mental health, violating the rights under articles 3 and 8.⁵⁴ These forcible interventions affecting the reproductive health status of women were found to be incompatible with the foundational rights principles of respect for freedom and dignity, especially when alternative methods were available and the intervention did not address any imminent life-threatening condition.⁵⁵ The case on forcible sterilization engaged with concerns similar to the constrained 'choice' of athletes coerced into undergoing medical interventions lacking any therapeutic objective.
36. Further, the coercive medical interventions under the Regulations, directed towards a specific set of women athletes who are identified and tested based on subjective standards around physical features and characteristics entail a violation of the right against discrimination based on sex guaranteed under article 14. The Regulations are devoid of reasonable and objective justifications, particularly given the contested scientific basis of claims of athletic advantage.

⁴⁹ CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)' (11 August 2000, E/C.12/2000/4).

⁵⁰ WMA, Human Rights – Physicians as Human Rights Advocates <<https://www.wma.net/what-we-do/human-rights/>> accessed 4 October 2021.

⁵¹ WMA, Women and Health – A Woman's Right to the Highest Standard of Health <<https://www.wma.net/what-we-do/human-rights/women-and-health/>> accessed 4 October 2021.

⁵² *Nada v Switzerland* App no 10593/08 (ECHR, 12 September 2012) [151].

⁵³ *Erdinc Kurt v Turkey* App no. 50772/11 (ECHR, 6 June 2017) [53].

⁵⁴ *VC v Slovakia* App no 18968/07 (ECHR, 8 November 2011) [118].

⁵⁵ *ibid* [113].

37. Moreover, in recognition of the overwhelming risks to rights provoked by interventions on persons with differences in sex development, the Parliamentary Assembly of the Council of Europe, along with other rights groups,⁵⁶ has cautioned against surgical or pharmacological interventions on children with intersex variations and differences in sex development precisely because they are conducted without informed consent, violate their physical integrity, respond to no immediate danger to health and hold no genuine therapeutic purpose nor evidence of long-term effectiveness or benefit.⁵⁷ These considerations apply equally to athletes investigated under the Regulations.

CONCLUSION AND IMPLICATIONS

38. The conditions for eligibility imposed by the Regulations threaten the patient-physician relationship as they ask physicians to violate their ethical obligations to athletes who come before them not for health-seeking but rather regulatory compliance reasons. It unfairly leaves athletes with the coerced “choice” to either submit to physical assessments, consult with physicians, and undergo unnecessary medical interventions with the potential for serious side effects or give up their livelihood.
39. Physicians are central to the Regulations: their implementation would be impossible without physicians’ involvement. Physicians’ conflicts of interest, arising in practice from their dual loyalties to the athletes and athletics federations under the Regulations, constrain them to offer unsuitable and harmful medical advice to athletes, as opposed to appropriate medical care that puts the patient’s health first.⁵⁸ Rather than offering holistic health care that is tailored and responsive to athletes’ specific concerns, the Regulations ask physicians to take steps which risk their ethical obligations. All other options that better respond to athletes’ needs are foreclosed.
40. The WMA’s Declaration on the Principles of Health Care for Sports Medicine adopted in 1981 reiterates that the health of athletes is the physician’s primary consideration and declares that physicians should have full freedom, especially when it comes to the health, safety and legitimate interests of athletes, and must uphold the ethical principles recognized in national and international statements.⁵⁹ Thus, the WMA reiterates its position that the Regulations “are contrary to international medical ethics and human rights standards.”⁶⁰ We ask this Court to recognize that the Regulations place physicians in an unacceptable position, and ultimately generate not just ethical violations but violations of the rights of those persons facing medical choices that those ethics were created to protect.

⁵⁶ ‘Unnecessary Surgery on Intersex Children Must Stop’ (Physicians for Human Rights, 20 October 2017) <<https://phr.org/news/unnecessary-surgery-on-intersex-children-must-stop/>> accessed 4 October 2021; Human Rights Watch, ‘I Want to Be Like Nature Made Me – Medically Unnecessary Surgeries on Intersex Children in the US’ [2017] <https://www.hrw.org/sites/default/files/report_pdf/lgbtintersex0717_web_0.pdf> accessed 4 October 2021.

⁵⁷ Promoting the human rights of and eliminating discrimination against intersex people [2017] RES 2191.

⁵⁸ Nancy M. P. King and Richard Robeson, ‘Athletes are Guinea Pigs’ [2013] Vol. 13(10) American Journal of Bioethics 13 <https://www.tandfonline.com/doi/pdf/10.1080/15265161.2013.828126?needAccess=true>.

⁵⁹ Declaration on Principles of Health Care for Sports Medicine [1981] <<https://www.wma.net/policies-post/wma-declaration-on-principles-of-health-care-for-sports-medicine/>> accessed 4 October 2021.

⁶⁰ WMA urges physicians not to implement IAAF Rules on classifying women athletes, n 30.