# MEDICAL SERVICES

*Technical Manual*

*on Medical Services*

# Technical Manual on Medical Services

NOVEMBER 2005

**International Olympic Committee**

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# I. Global Reference Data

**Name** **Technical Manual on Medical Services**

**Date/Version** November 2005

**Note** This manual is part of the IOC Host City Contract. It will often refer to other IOC documents and manuals in an effort to synthesize information under specific functions.

In order to provide Games organisers with a complete picture of a Games function, both Olympic and Paralympic information is integrated within the technical manuals. General information may apply to both Olympic and Paralympic Games even though not explicitly mentioned, while Paralympic-specific information is identified as such.

### Disclosure

The material and the information contained herein are provided by the IOC to be used for the sole purpose of preparing, organising and staging an edition of the Olympic Games. This material and information is the property of the IOC and may not be disclosed to third parties or the general public, whether in whole or in part, without the prior written approval of the IOC. Sharing of such material and information is only permitted, under the condition of strict confidentiality, with third parties assisting in the preparation, organisation and staging of an edition of the Olympic Games.

# II. Changes from Previous Version

**Introduction** This section lists the changes found in this version in relation to the previous.

**Context** Please note that this is a new document created as part of the IOC initiative to update and standardise the technical manuals provided to the OCOGs. This Manual provides detailed Health Care and Doping Control planning information not previously provided to a Candidate City or an OCOG. It consolidates requirements found in various documents, including those relating to external agencies such as the World Doping Control Code, and distinguishes recommendations from obligations to assist the OCOG and anticipate various issues relating to Medical Services.

# III. Related Documents

**List**

The following is a list of all documents this Technical Manual refers to:

- Olympic Charter
- Host City Contract
- Accreditation and Entries at the Olympic Games – User's Guide
- Technical Manual on Brand Protection
- Technical Manual on Olympic Village
- Technical Manual on Paralympic Games
- Technical Manual on Workforce
- Technical Manual on Accommodation
- Technical Manual on Planning, Coordination, and Management of the Olympic Games
- Technical Manual on Venues - Design Standards for Competition Venues
- Technical Manual on Transport
- Technical Manual on Sport
- World Anti-Doping Code
- International Standard for Testing
- International Standard for Laboratories
- International Standard for the Prohibited List
- International Standard for Therapeutic Use Exemptions
- Models of Best Practice
  - Test Distribution Planning Guidelines
  - Urine Collection Guidelines
  - Blood Collection Guidelines
  - Sample Collection Personnel: Recruitment, Training, Accreditation and Re-Accreditation Guidelines

Games related Doping Control Documents:

- IOC Anti-Doping Rules
- IPC Anti-Doping Code
- Technical Doping control procedures – Olympic Games
- Doping Control Guide - Paralympic Games
- WADA Independent Observer Reports: Sydney 2000, Salt Lake City 2002, and Athens 2004.

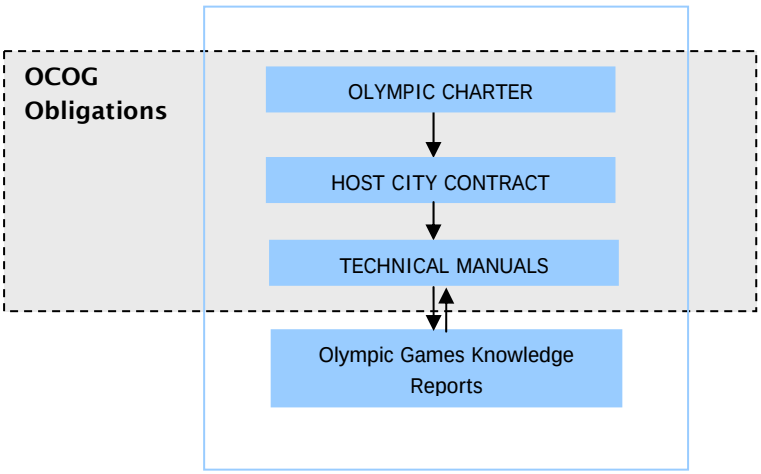
# IV. Information Road Map

**Introduction**

The aim of this section is to explain how the Technical Manuals fit into the general context of the various IOC guidelines and supporting documents. The Technical Manuals are part of an information chain that needs to be clearly understood by all Games organisers including OCOGs, government entities, and partners, as well as by bidding cities. This will enable them to understand their obligations and distinguish them from the recommendations and advice provided through the Olympic Games Knowledge Programme.

**Presentation**

The diagram below illustrates the "information road map" and the position of the Technical Manuals within the context of other related documents. Each of the documents is described in more detail on the following pages.

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# IV. Information Road Map, Continued

**Olympic Charter (OC)**

The Olympic Charter governs the organisation and operation of the Olympic Movement, and stipulates the conditions for the celebration of the Olympic Games. It is the codification of the:

- Fundamental Principles
- Rules
- Bye-laws

as adopted by the IOC. Thus, the Olympic Charter represents the permanent fundamental reference document for all parties of the Olympic Movement. It can only be modified with the approval of the IOC Session. The Olympic Charter is updated periodically and therefore, the only applicable version is the most current version.

**Host City Contract (HCC)**

The Host City Contract sets out the legal, commercial, and financial rights and obligations of the IOC, the host city and the NOC of the host country in relation to the Olympic Games. The Host City Contract represents the written agreement entered into between the:

- IOC, on the one hand
- Host city and NOC of the host country, on the other hand

In case of any conflict between the provisions of the Host City Contract and the Olympic Charter, the provision of the Host City Contract shall take precedence.

The Host City Contract is signed by the IOC, the host city and the NOC of the host country immediately following the announcement by the IOC of the host city elected to host the Olympic and Paralympic Games. As such, the Host City Contract is specific to each edition of the Olympic Games, and may vary from Games to Games due to changes and modifications.

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# IV. Information Road Map, Continued

**Technical Manuals**

The Technical Manuals annexed to the Host City Contract form an integral part thereof. They contain the following information regarding a given subject/theme of Olympic Games organisation:

- Detailed technical obligations
- Planning information
- Procedures and processes
- Proven practices

Thus, they provide the technical requirements and information for the implementation of the key functions by the OCOGs and their partners. The IOC may amend the Technical Manuals and update them as necessary to include the most recent and relevant information for the Games organisers. Therefore, the only applicable version of any Technical Manual is the most current version. The English version of the manuals shall prevail.

**Olympic Games Knowledge Reports (Formerly called "TOK Guides")**

The Olympic Games Knowledge Reports* represent a description of practices and experiences from previous Games organisers, referring to a given local host city context and environment.

The reports contain:

- Technical and organisational information from the OCOG's point of view referring to a given edition of the Olympic Games. This can include practice examples, scale and scope data, as well as information on resources, planning, strategy and operations.

They do not contain:

- Legal obligations
- IOC recommendations

Once edited after each edition of the Olympic Games, the Olympic Games Knowledge Reports are no longer modified. For this reason, there is one version of reports that is specific to each edition of the Olympic Games.

** These reports are part of the Olympic Games Knowledge Programme put in place by the IOC to facilitate the transfer of Olympic Games Knowledge and assist in the exchange of information from one Olympic Games to the next. The programme comprises several components (written information, workshops etc.) and features the Olympic Games Knowledge Reports as one of its key elements. These reports can be found on the Olympic Games Knowledge Extranet.*

# V. Olympic Games Study

**Introduction**

This section provides an introduction to the work undertaken by the IOC that directly impacts Games preparation, operations, and long-term sustainability. Therefore, it is crucial for the reader of this manual to understand the general context and philosophy of the IOC, which will help adopt the mindset of cost consciousness and continuing improvement introduced by the IOC. Detailed technical recommendations from Olympic Games Study have been incorporated directly in the manual-specific content.

**Games Study Commission**

The Olympic Games Study Commission was established by IOC President Jacques Rogge to analyse the current scale and scope of the Olympic Games and the Olympic Winter Games. The Commission's mandate was to propose solutions to manage the inherent size, complexity and cost of staging the Olympic Games in the future, and to assess how the Games can be made more streamlined and efficient.

The decision to undertake this work recognises the IOC's desire to maintain the position of the Games as the most important sporting event in the world while, at the same time, balancing the need to keep the impacts associated with Games organisation under reasonable control. In particular, the IOC addressed measures to ensure that Games Host Cities do not incur greater expenses than are necessary for the proper organisation of the Games.

The IOC ensured that proposed measures should not undermine the universal appeal of the Games, nor compromise the conditions which allow athletes to achieve their best sporting performance, and which allow the media to transmit the unique atmosphere and celebration of the Games to the world.

The Commission presented its complete report to the IOC Session in Prague in July 2003. At this meeting, the general principles and detailed recommendations were adopted as well as the calendar of dates for the implementation of these recommendations.

The IOC Olympic Games Department owns the task of managing the detailed implementation of all recommendations. The objective is to integrate the recommendations and principles of the study into the general IOC guidelines and Games management processes, so that future Games organisers will automatically work from this basis. At the same time, it is essential that the organisers understand and adopt its general philosophy and guiding principles.

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# V. Olympic Games Study, Continued

**Main Recommendations of Games Study Report**

The Olympic Games Study report lists 117 detailed practical recommendations, which have been structured according to five major themes. Please note that the detailed recommendations have been incorporated in relevant parts of the Technical Manuals. Detailed information can be found in the complete report; however, the following represents a general explanation of the five major themes:

### 1. Games Format

The IOC should re-affirm the following Olympic Charter principles:

- The Olympic Games are awarded to a single Host City
- The duration of competitions shall not exceed 16 days
- Only sports practised on snow and ice may be considered as winter sports

### 2. Venues & Facilities

Minimise the costs and maximise the use of competition, non-competition and training venues and guarantee an efficient usage in terms of time, space and services, while taking into consideration the needs of the Olympic Family.

### 3. Games Management

Recognising the fact that the Games are evolving, the IOC should clearly define its role and responsibilities within the Olympic Movement vis-à-vis all involved parties with the objective of improving Games governance. The OCOG should adopt more effective business processes with the objective of creating a more efficient and coordinated Games management through work practices that maximise all resources.

### 4. Number of Accredited Persons

The IOC should establish appropriate guidelines and find ways of containing (and ideally decreasing) the overall number of accredited persons on the occasion of the Games. The focus should be on groups that have experienced the most dramatic increases, those that have more flexible rules and those that do not have any maximum numbers.

### 5. Service Levels

Stop the ever increasing "benchmark inflation" that arises from comparisons of services provided at past Games or other major events. Service levels should be of a reasonable standard and be adapted to each client groups' real needs. Acceptable risk levels must also be addressed with some key stakeholders.

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# V. Olympic Games Study, Continued

**Games Debriefing & Post-Games Analysis**

### Games Debriefing

Following every edition of the Games, a formal debriefing is conducted with the participation of the following:

- IOC
- OCOG having just organised the Games
- OCOG to organise the subsequent edition of the Games in four years time

The debriefing takes place within months immediately following the Games, and in the city of the next OCOG. At this time, a high-level analysis is conducted on the strategy, planning and operations of that specific edition of the Games, with the intention of passing on key conclusions and recommendations for the next organisers to improve the delivery of the Games.

### Post-Games Analysis

Based on the various analysis, reports, and observation of each Games edition, the IOC gathers all relevant information and presents a final summary report. Within this report, the IOC proposes the major policy changes and key actions necessary to implement improvements for future Games. Following the necessary approval, these key conclusions are adopted and integrated into the IOC guidelines, forming the framework for future Games organisers.

**Olympic Games Global Impact (OGGI)**

In recognising the importance of sustainable development and social responsibility, the IOC launched the OGGI project with the objective to:

- Measure the global impact of the Olympic Games
- Create a comparable benchmark across all future Games editions
- Help bidding cities and future organisers identify potential legacies to maximise the Games' benefits

OGGI takes into account the specificities of each Games and related host city context, and covers economic, social and environmental dimensions. The main OGGI report forms part of the Official Report to be produced by the OCOG after each Games, and therefore is an official requirement to be fulfilled by each Host City.

The OGGI project allows for the IOC to measure the long-term implications of Games organisation, in order to analyse the global impact of the Games on a given host city. Based on the findings, the IOC integrates the appropriate changes to maintain the long-term viability and success for the Games in keeping with the ideals of the Olympic Movement.

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# V. Olympic Games Study, Continued

**Key Messages**

- As a responsible organisation, the IOC wants to ensure that host cities and residents are left with the best possible legacy in terms of venues, infrastructure, environment, expertise and experience.
- Bigger does not necessarily mean better and higher expenditure does not necessarily guarantee the quality of the Games. The IOC made clear that excessive or unjustified costs and infrastructure could even be counterproductive.
- Games Study should involve the commitment and participation of all Olympic stakeholders, as the improvements will ultimately be to their benefit as well. The notions of "teamwork" and striving for the same goal are key in this context.
- It has to be ensured that the underlying philosophy and conclusions with regard to the size and complexity of the Olympic Games are widespread, understood, and properly assimilated within the Olympic Movement and beyond.
- No single recommendation can provide a solution, but the sum is reflective of an attitude and mindset that should be adopted by all parties of the Olympic Movement.
- Underpinning this approach, the IOC has strengthened its support and collaboration with the Games organisers through, for example, enhanced Games management processes, and a strong transfer of knowledge programme to provide assistance and advice as needed.

# VI. Introduction

**Objectives**

The objectives of the Technical Guide on Medical Services are to:

- Facilitate the OCOG and Host City's understanding and planning of Medical Services for the Games.
- Identify the scope, level of service, and general principles required for effective medical and doping control programmes in accordance with standards established by the IOC and other relevant organisations.
- Help Candidate Cities understand Medical Services requirements in a Games setting.
- Address technical information regarding an OCOG's obligations.
- Make recommendations to an OCOG regarding procedures and processes by which those obligations may be met.

**Limits**

This manual describes planning and operational requirements for the OCOG Medical Services programme, and explains the key obligations, responsibilities and planning processes of the OCOG. However, it does not address how such medical services will be delivered during the Games period. This limitation recognizes the variability of regulatory governance and clinician roles existing across the global medical community.

The sample collection and sample handling parts of the Doping Control process, known as "Testing", are referred to but not described in detail as the detail can be found in the documents referenced.

It is does not include details about the laboratory analysis, result management, hearings and appeals part of the Doping Control process as these processes are not the responsibility of the OCOG.

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# VI. Introduction, Continued

**Target Audience**

The target audience for this manual is:

- OCOG Medical Services function
- OCOG Doping Control function
- OCOG Senior Executives
- Other affected OCOG Functions
- Candidate Cities
- IOC Medical Commission
- IPC Medical & Scientific Department
- Public Health Authorities of the Host City

NOTE

It will be helpful for the OCOG to share certain sections of the manual with representatives of the public and private medical organisations of the Host City and Host Country. Relevant parts of the doping control section should also be shared with the OCOG's Sport and/or other Functions that will be impacted by these programmes.

**Context**

The Technical Manual on Medical Services is intended to define planning considerations relating to health and medical resources and the complex integration issues associated with providing health care in the host city or country. Many public and private organisations will participate in the provision of medical services at the time of the Games. It is the responsibility of the OCOG to ensure an effectively integrated approach to the planning and delivery of services.

The manual also integrates the many aspects and participants regarding Doping Control rules, regulations and activities relating to the Games. Many of which are external and independent organisations that play an important role in the process such as the World Anti-Doping Agency.

# VII. Executive Summary

**Overview of Medical Programme**

During the Games period, the OCOG's Medical Services function is responsible for the medical care and health planning for all constituent groups associated with the Games including athletes and other members of the Olympic Family, spectators, the workforce, media, sponsors, and guests of the Olympic Family. The OCOG will provide a coordinated delivery of medical care inside the Games venues and will ensure that appropriate medical care is available outside of the Games venues.

During the Games period, members of the IOC Medical Commission will be present to observe and advise the OCOG's medical and doping control team. The OCOG Chief Medical Officer (CMO), as full member of the IOC Medical Commission Games Group, is the link between the IOC Medical Commission and OCOG Medical Services. Remarks, criticisms or any other problem should be immediately reported to the CMO. Therefore, the OGOC must make certain provisions for the IOC Medical Commission during the Games period and these requirements will be reviewed.

**Part I – Health Care**

During the Games period, the OCOG's Medical Services function is responsible for the medical care and health planning for all constituent groups associated with the Games including athletes and other members of the Olympic Family, spectators, the workforce, media, sponsors, and guests of the Olympic Family. The OCOG must provide a coordinated delivery of medical care inside the Games venues and ensure that appropriate medical care is available outside of the Games venues. This part describes the general principles of the health care programme, scope of medical care for each constituent group, special provisions for the Olympic Family medical programme, medical transportation, relation with the public health authorities, disaster planning, and guarantees and operational issues.

**Part II – Doping Control**

The Doping Control Programme is responsible for the planning and delivery of the infrastructure necessary to implement the Doping Control Programme at the Olympic Games and the Paralympic Games, in accordance with the requirements of the IOC, IPC and in compliance with provisions of the World Anti-Doping Code and accompanying International Standards. This part outlines the General Principles, roles and responsibilities and key documents and structures related to the OCOG's Doping Control Programme.

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# VII. Executive Summary, Continued

**Part III – IOC Medical Commission**

During the Olympic Games, certain members of the IOC Medical Commission will participate as working members of the Commission to observe, assess, and support the Medical Services and Doping Control functional programmes. This part describes the various activities and responsibilities for this group, including monitoring the doping control tests carried out by the OCOG, liaising with the team doctors, in the Olympic Village and at the venues, monitoring injuries, and analyse the medical data provided by Medical Services. They will also monitor dental and physiotherapy services in close cooperation with Medical Services.

# VIII. Technical Presentation

**Document Structure**

The organisation of Medical Services for the Olympic Games is divided into two principle themes:

- Health Care
- Doping Control

Although these represent two distinct programmes within an OCOG, this manual treats both subjects as they both fall under the concept of Medical Services, and are closely related within Games management. This manual lays out the obligations and recommendations to execute these two functions. These two themes are covered in the first two parts of this manual.

The third part of this document covers details concerning the IOC Medical Commission.

**Scope**

This Technical Manual addresses Medical Services at an Olympic Games and Paralympic Games and how an OCOG may successfully plan its Health Care and Doping Control Programmes in support of the delivery of the Games. This manual addresses both programmes in separate parts of the document, as well as the relationship and needs of the IOC Medical Commission in relation to the Games.

The manual helps Applicant and Candidate Cities understand what is required of them with regard to Medical Services as they seek election as Host City of future editions of the Games by obligations and provides a framework for structuring their Medical Services programme.

The manual outlines the international framework and policies, specifically relating to Doping Control, to assist and increase the OCOG's understanding of relevant issues.

**Position in OCOG Structure**

The Medical Services function within an OCOG is responsible for the delivery of health care to the various constituents at the Games in coordination with the Host City's general medical services and community

The Doping Control Programme may be positioned within another Function in order to best serve the needs of the OCOG, such as Games Services (Athens 2004) or Sport Division (Sydney 2000).

The key contact for the OCOG and Host City organisations within the IOC is the IOC Medical Director, but will also require a close working relationship with the IFs, other Olympic stakeholders, and international agencies. The key contact for the IPC is the IPC Medical & Scientific Director.

# IX. Link to OCOG Phases

**Introduction**

The following table overlays the evolution phases of an OCOG (per the Generic Planning Process as described in the Technical Manual on Planning, Coordination, and Management of the Olympic Games) with descriptions of responsibilities to be completed by the Medical Services Function.

**Health Care**

The following table lists the main responsibilities for Health Care:

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 1 | Foundation | G-98 to G-66 | • Main internal discussion with other generic functions<br>• Definition of the department and to which function<br>• The department should be attached to.<br>• Appointment of the Chief Medical Officer (may be part time at the beginning)<br>• Identify existing medical care programmes, expertise and resources within Host Country/City<br>• Establish working relationship with governmental bodies and/or agencies<br>• Establish small working committee to look at issues until programme Manager is hired<br>• Starting relations with IOC Medical Commission |
| 2 | Strategic Planning | G-65 to G-42 | • Medical Strategic plan completed<br>• Establish organisational structure of programme<br>• commence development of service agreement with public authorities<br>• Build strategic plans and related budgets<br>• Identify baseline headcount and workforce requirements)<br>• Identify expected accommodation needs of workforce<br>• Identify space requirements in competition<br>• Hospitals and Emergency services agreements signed |

Continued on next page

# IX. Link to OCOG Phases, Continued

**Health Care** (continued)

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 3 | Operational Planning | G-41 to G-6 | • Recruit fulltime workforce – minimum - Assistant programme Manager, Workforce Coordinator, four Venue/Operations Coordinators, Administrator<br>• Commence recruitment and training (workshop and field) of field workforce<br>• Complete Medical Concept of Operations<br>• Participate in Venue Planning processes<br>• Refine space and FF&E requirements – Competition and non-competition venues<br>• Identify technology, communication, publication, language services, catering, waste management sport information and security needs in each Venue<br>• Identify transport needs and<br>• Identify and procure equipment<br>• Identify contingency risks and processes for handling such risks<br>• Identify any issues relating to national police and customs requirements<br>• Finalise workforce accommodation needs<br>• Medical functional Operations Plan completed<br>• Medical Model Venue Operational Plan completed<br>• Medical Specific Venues Operations Plan completed |
| 4 | Testing | G-24 to G-6 | • Execute normal operational mode during events |

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# IX. Link to OCOG Phases, Continued

**Health Care** (continued)

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 5 | Operational Readiness | G-5 to G-1 | • Commence Test Event programmes and evaluate space, workforce and FA interactions after each Event<br>• Finalise Games time operational interactions with other Functions<br>• Finalise agreements<br>• Finalise all internal and external policies and procedures, and all Venue Manuals<br>• Finalise field workforce headcount<br>• Appoint all field workforce to Games time positions and finalise all rosters<br>• Finalise space and FF&E requirements – Competition and non-competition venues<br>• Receive and re-distribute all equipment<br>• Finalise all paperwork, forms |
| 6 | Games Operations | Games, Transition, & Paralympics | • Execute Games-time operations |
| 7 | Dissolution | G to G+12 | • Post Games reports completed |

**Doping Control** The following table lists the main responsibilities for Doping Control:

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 1 | Foundation | G-98 to G-66 | • Identify existing Doping Control programmes, expertise and resources within Host Country/City<br>• Establish working relationship with such bodies/agencies<br>• Establish small working committee to look at issues until programme Manager is hired<br>• Identify if WADA-accredited Laboratory exists in the country and if not the feasibility of establishing a permanent or temporary Accredited Laboratory. |

Continued on next page

# IX. Link to OCOG Phases, Continued

**Doping Control** (continued)

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 2 | Strategic Planning | G-65 to G-42 | • Hire Doping Control Programme Manager (may be part-time to start with, or resource provided by National Anti-Doping Organisation)<br>• Study current Doping Control policies, including World Anti-Doping Code<br>• Establish organisational structure of programme<br>• Determine Laboratory situation and commence development of service agreement<br>• Build strategic plans and related budgets<br>• Develop draft Test Distribution Plan (TDP)<br>• Identify baseline headcount and workforce requirements for field based on TDP and determine situation re expertise being within country and basis of workforce recruitment (volunteers or not)<br>• Identify expected accommodation needs of workforce<br>• Identify space requirements in competition venues based on TDP<br>• Educate OCOG about Doping Control and its requirements |
| 3 | Operational Planning | G-41 to G-6 | • Recruit fulltime workforce – minimum - Assistant programme Manager, Workforce Coordinator, four Venue/Operations Coordinators, Administrator<br>• Commence recruitment and training (workshop and field) of field workforce<br>• Complete Doping Control Concept of Operations<br>• Participate in Venue Planning processes<br>• Refine space and FF&E requirements – Competition and non-competition venues<br>• Identify technology, communication, publication, language services, catering, waste management sport information and security needs in each Venue<br>• Identify transport needs and solutions (people and samples)<br>• Identify and procure sample collection equipment<br>• Identify WADA requirements<br>• Identify contingency risks and processes for handling such risks<br>• Identify any issues relating to national police and customs requirements<br>• Finalise workforce accommodation needs |

Continued on next page

# IX. Link to OCOG Phases, Continued

**Doping Control** (continued)

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 4 | Testing | G-24 to G-6 | • Execute normal operational mode during events |
| 5 | Operational Readiness & | G-5 to G-1 | • Commence Test Event Doping Control Programmes and evaluate space, workforce and FA interactions after each Event<br>• Finalise Games time operational interactions with other Functions<br>• Finalise Test Distribution Plan<br>• Finalise agreements with IOC, IFs, WADA, Laboratory<br>• Finalise all internal and external policies and procedures, including Doping Control Operations Manual and all Venue Manuals<br>• Finalise field workforce headcount<br>• Appoint all field workforce to Games time positions and finalise all rosters<br>• Finalise space and FF&E requirements – Competition and non-competition venues<br>• Finalise and distribute Technical Doping control procedures, Prohibited List and other information resources e.g. Video<br>• Receive and re-distribute all sample collection equipment<br>• Finalise all paperwork, forms<br>• Secure all specialised equipment /forms in locked down Doping Control Stations<br>• Finalise all transport and courier requirements<br>• Conduct Final Workshop for all Doping Control workforce<br>• Finalise /facilitate completion of media strategy for OCOG, IOC, NADO and Laboratory for Games time |

Continued on next page

# IX. Link to OCOG Phases, Continued

**Doping Control** (continued)

| | Phase | Month | Responsibilities |
|---|---|---|---|
| 6 | Games Operations | Games, Transition, & Paralympics | • Conduct Out-of-Competition Testing programme<br>• Conduct In-Competition Testing Programme<br>• Support IOC in Result Management processes<br>• Support IOC and WADA to complete their respective responsibilities<br>• Transition of Doping Control Stations to Paralympic Games mode, including the addition of any required specialised sample collection equipment<br>• Conduct Out-of-Competition Testing programme<br>• Conduct In-Competition Testing Programme<br>• Support IPC in Result Management processes<br>• Support IPC and WADA to complete their respective responsibilities |
| 7 | Dissolution | G to G+12 | • Recognition of workforce – celebrations<br>• Removal of all sample collection equipment and legacy arrangements completed<br>• Ensure all payments completed/underway<br>• Post Games reports completed |

# X. Master Schedule Reference

**Update to Master Schedule**

NOTE

The next generation of the Master Schedule is currently under completion and will be released at a later date. Once released, it shall take precedence over the critical milestones and delivery dates as found in this manual.

# XI. Obligations Checklist

**Introduction**

The following list represents a summary of the critical obligations related to Medical Services. This list gives only a high-level view of the relevant obligations in this area, while all of the complete and detailed responsibilities are found within the main text of this manual.

**Health Care Obligations**

- The OCOG is required to provide care for acute and emergency illness or injuries of the athletes, Olympic Family, and Olympic-related guests during the Games period and to respond to injuries and illness that arise to any one at the Olympic competition and non-competition venues.
- The City, the NOC, and the OCOG shall be deemed responsible for all aspects of medical/health service related to the Games, through the appropriate authorities in the City and the Host Country.
- The City, the NOC and the OCOG shall be responsible for ensuring the implementation of all necessary and appropriate medical/health service measures, including repatriation, in accordance with the instructions received from the IOC.
- Medical services shall be provided free of charge to the following accredited persons: competitors, team officials and other team personnel, technical officials, media, sponsors/suppliers/licensees and representatives of the IOC, the IFs and the National Olympic Committees and other persons at the Games as designated by the IOC, for all medical conditions occurring during their stay in the Host Country for the Games.
- The extent and level of such services shall be subject to the prior written approval of the IOC.
- The OCOG shall secure and maintain, adequate insurance coverage in respect of all risks associated with the planning, organising and staging of the Games, including:
  - Third party risks in order to cover all such third parties against, without limitation, bodily injury property damage, or purely financial risks including professional liability
  - Accident and medical health insurance, including repatriation

**Doping Control Obligations**

- The OCOG, at its expense, shall put into place and carry out, doping controls, under the authority of the IOC, in accordance with instructions received from the IOC and the provisions of the World Anti-Doping Code and the IOC Anti-Doping Rules that will be applied by the IOC at the time of the Games.
- The World Anti-Doping Code is mandatory for the whole Olympic Movement.

**IOC Medical Commission Obligations**

- At Games-time, the OCOG must make provisions to ensure the IOC MC has adequate resources and a base of operations.

# XII. Specific Glossary

**Presentation** This section defines the different specific terms used throughout this manual. Please note that this manual may also use the Olympic core terminology created by the IOC and which is usually delivered in combination with the complete set of all Technical Manuals. This core terminology comprises approximately 400 general terms, which are among the most used terms for the Olympic Games organisation. The following table gives a list and definitions of terms and acronyms used in this manual specific to the subject.

**Glossary** The following defines the specific Medical Services terminology:

| Term | Definition |
|---|---|
| Anti-Doping Organisation | A Signatory of the World Anti-Doping Code that is responsible for adopting rules, for initiating, implementing or enforcing any part of the Doping Control Process. This includes, for example, the IOC, the IPC, International Federations and National Anti-Doping Organisations. |
| Blood Collection Officer | An official who is qualified to and has been authorised by the ADO to collect a blood sample from an Athlete. |
| Chain of Custody | The sequence of individuals and organisations that have the responsibility for a sample/specimen from the provision of the Sample/specimen until the Sample/specimen has been received for analysis. |
| Chief Medical Officer (CMO) | The Chief Medical Officer is the individual that is responsible for the entire OCOG medical programme, including oversight of the integration with community-based health services. The CMO is also responsible for the OCOG's Doping Control Programme. |
| Code | The World Anti-Doping Code |
| Doping Control Officer | An official who has been trained and authorised by the ADO with delegated responsibility for the on-site management of a Sample Collection Session. At Games-time a manager of each Venue Doping Control is appointed – the Doping Control Venue Manager. |
| Doping Control Station | The location where the Sample Collection Session will be conducted. |
| Doping Control Station Coordinator | The Station Coordinator is responsible for the set-up and management of the services within the Doping Control Station. A Doping Control position usually appointed at Games time |

Continued on next page

# XII. Specific Glossary, Continued

**Glossary** (continued)

| Term | Definition |
|---|---|
| Doping Control Venue Manager | The Manager of Doping Control at the Venue. A Doping Control position usually appointed at Games time. |
| Doping Control Chaperone | An official who is trained and authorised by the ADO to carry out specific duties including notification of the Athlete selected for Sample collection, accompanying and observing the Athlete until arrival at the Doping Control Station, and/or witnessing and verifying the provision of the Sample where the training qualifies him/her to do so. |
| Doping Control Chaperone Coordinator | An official responsible for a group of Chaperones. A Doping Control position usually appointed at Games time. |
| Emergency Medical Services (EMS) | Emergency Medical Services, as referenced by "EMS," generally refers to the community-based ambulance teams. The term EMS can refer to EMS staff including physicians, nurses, paramedics, emergency medical technicians and to EMS resources such as air ambulances (e.g. med-evac helicopters), ground ambulances, bicycle units, and special response units such as medically-equipped golf carts or gators. |
| Hospital Olympic Liaison Officer (HOLO) | An individual, assigned by the administration of the Olympic Hospital and approved by the OCOG Chief Medical Officer, who has responsibility for coordinating pre-Games preparations at the Olympic Hospital and who will be the contact person at Games-time for facilitating care of athletes or Olympic Family members. |
| In Competition | For purposing of differentiating between In-Competition and Out-of-Competition Testing, unless provided otherwise in the rules of an International Federation or other relevant Doping Control Organisation, an In-Competition Test is a test where an athlete is selected for Testing in connection with a specific Competition. |
| Independent Observer Programme | A team of observers, under the supervision of WADA, who observe the Doping Control process at certain Events and report on observations. |
| International Standard | A standard adopted by WADA in support of the Code. Compliance with an International Standard (as opposed to another alternative standard, practice or procedure) shall be sufficient to conclude that the procedures addressed by the International Standard were performed properly. |

Continued on next page

# XII. Specific Glossary, Continued

**Glossary** (continued)

| Term | Definition |
|---|---|
| Mass Casualty Incident (MCI) | A mass casualty incident is generally defined as an incident with a number of injured individuals that requires the activation of multiple response resources or agencies. An MCI typically requires implementation of an incident command structure. |
| Medical Headquarters (MHQ) | The OCOG's Medical Headquarters will provide a base of operations and communication for the multi-site Olympic Medical Programme implemented at the venues, Village, IOC Hotel, media centre(s), as well as community-based the EMS dispatch centre, hospitals, and clinics. Activities supported by the MHQ include communication related to significant medical events, back-up medical volunteer staffing, medical supply inventory management, Olympic Family case management, resolution of operational issues at the venues, etc. |
| National Anti-Doping Organisation | The entity(ies) designated by each country as possessing the primary authority and responsibility to adopt and implement Doping Control rules, direct the collection of Samples, the management of test results, and the conduct of hearings, all at the national level. If this designation has not been made by the competent authority (ies) the entity shall be the country's National Olympic Committee or its designee. |
| Olympic Hospital | A hospital, which has been identified by OCOG to be part of the Olympic Medical Network, either due its proximity of venues, either due to its specialties. Different Olympic Hospitals may be identified for each group of the Olympic Family |
| Out-of-Competition | Any Doping Control which is not In-Competition |
| Prohibited List | The List identifying the Prohibited Substances and Prohibited Methods. |
| Sample/Specimen | Any biological material collected for the purposes of Doping Control. |
| Sample Collection Equipment | Containers or apparatus used to directly collect or hold the Athletes Specimen at any time during the Sample Collection process. |
| Target Testing | Selection of Athletes for Testing where specific Athletes or group of Athletes are selected on a non-random basis for Testing at a specified time. |
| Test Distribution Plan - TDP | The number of doping controls to be conducted by day, by sport, by type of sample and by timing of notification. |
| Testing | The parts of the Doping Control process involving test distribution planning, Sample Collection, Sample Handling, and Sample transport to the laboratory |
| Venue Medical Officer (VMO) | The Venue Medical Officer is the individual responsible for the Medical Programme at the venue level. The VMO is accountable to the Chief Medical Officer of the OCOG and to the Venue Manager or Venue General Manager. |

Continued on next page

# XII. Specific Glossary, Continued

**Icons**

The following table provides definitions of the icons and colours used in this manual.

| Icon and Colour | Type of Information |
|---|---|
| △ | Obligation |
| ⬚ | Third party reference |
| ▶ IPC | IPC Reference |
| ✕ | Cross-Reference |

**Disclaimer**

Please note that these symbols as well as the grey background indicating OCOG obligations are used for illustration purposes to guide the reader through this manual, without however limiting the general validity and contractual character of this document.

# PART 1 → Health Care

## Executive Summary

**Introduction**

During the Games period, the OCOG's Medical Services Function is responsible for the medical care and health planning for all constituent groups associated with the Games including athletes and other members of the Olympic Family, spectators, the workforce, media, sponsors, and guests of the Olympic Family. The OCOG should provide a coordinated delivery of medical care inside the Games venues and ensure that appropriate medical care is available outside of the Games venues.

**Contents**

This part contains the following topics:


| Topic |
|---|
| 1.0 General Principles |
| 2.0 Medical Care - Athletes |
| 3.0 Medical Care - Spectators, Workforce, & Media |
| 4.0 Medical Care - Olympic Family |
| 5.0 Medical Transport |
| 6.0 Relationship with Public Health Authorities |
| 7.0 Disaster Planning |
| 8.0 Guarantees & Operational Issues |

# 1.0 → General Principles

## Executive Summary

**Introduction**

This chapter describes the general scope of the medical services programme, as well as the role of the Chief Medical Officer, the OF insurance programme for medical coverage, and the professional liability insurance programme for the OCOG's medical team. This chapter also includes information about regulatory issues that would impact the right to practice medicine within the Olympic Medical Programme.

The OCOG Medical Services function should support a philosophy to ensure:

- Excellence in the provision of health care services to all Olympic/Paralympic constituents;
- Effective teamwork among and between all OCOG functions and the health care community; and
- Community involvement during planning and implementation phases.

### Relation with Host City Medical Community

It is imperative that the local level of medical care to community is not compromised during the Games period. In providing such a programme, it is important to clearly define the level of services to be provided, to identify which organisations will provide services and where such services will be offered, and to communicate such information to all relevant groups.

**Contents**

This chapter contains the following topics:

| Topic |
|---|
| 1.1 Scope of Medical Coverage |
| 1.2 Chief Medical Officer |
| 1.2 Insurance |
| 1.3 Right to Practice Medicine |

# 1.1 Scope of Medical Coverage

**Introduction**

This section covers the scope of medical coverage defined by location of services (venues, village, community) and by constituent group receiving services (athletes, other Olympic Family members, media, workforce, and spectators).

**Principle Obligations** △

- The OCOG must provide care for acute and emergency illness or injuries of the athletes, Olympic Family, and Olympic-related guests during the Games period and to respond to injuries and illness that arise to any one at the Olympic competition and non-competition venues.
- The City, the NOC, and the OCOG shall be deemed responsible for all aspects of medical/health service related to the Games, through the appropriate authorities in the City and the Host Country.
- The City, the NOC and the OCOG shall be responsible for ensuring the implementation of all necessary and appropriate medical/health service measures, including repatriation, in accordance with the instructions received from the IOC.
- Medical services shall be provided free of charge to the following accredited persons: competitors, team officials and other team personnel, technical officials, media, sponsors/suppliers/licensees and representatives of the IOC, the IFs and the National Olympic Committees and other persons at the Games as designated by the IOC, for all medical conditions occurring during their stay in the Host Country for the Games.
- The extent and level of such services shall be subject to the prior written approval of the IOC.

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# 1.1 Scope of Medical Coverage, Continued

**Dates of Service**

▸ IPC

The Medical Programme must be operational from the pre-Opening until the closing of the Olympic Village and, as set forth in the IPC guidelines, from the opening until the closing of the Paralympic Village. The OCOG must be sure to clearly communicate the dates of service to the covered constituent groups. If medical services are likely to be required by these groups outside of the dates of service – the OCOG should provide information regarding access to community-based health care services in the host city.

There may be Olympic-related operations in the venue cities that extend beyond these dates of service, such as early operation of the International Broadcast Centre or Main Press Centre; unofficial training at the venues just prior to official training periods and build-out phases of the villages or venues. In these instances, the OCOG should ensure that community-based medical resources are available. The OCOG Medical Services Programme may choose to expand its dates of coverage in some of these locations.

**Geographic Area Covered by Medical Programme**

Games programmes can span multiple cities so the geographic area covered may be as broad as the entire host country. The geographic area covered by the Medical Programme must include each Olympic venue, the athletes' village(s), the media village(s), the IOC hotel(s) and surrounding areas. If venues or travel routes are near a country's borders, it may be appropriate to develop agreements with neighbouring countries to allow their health care resources to be included as an extension of the OCOG Medical Programme.

The OCOG should review the proposed geographic area to be covered with the IOC Medical Director who can provide counsel regarding the appropriateness of the coverage.

Continued on next page

# 1.1 Scope of Medical Coverage, Continued

**Venue Medical Services**

Any individual, if physically present at the venue, should be served by the OCOG's Medical Programme. There should be separate medical stations and medical response teams for the athletes due to restricted access to athlete preparation and competition areas. The medical resources dedicated to "others" will serve the spectators, Olympic Family (OF), media, sponsors, and workforce.

- Athletes' care includes medical response to the field of play (FOP); and limited emergency /primary care/sports medicine services provided in the athletes medical station. The OCOG and NOC medical teams work together in providing care to the athletes at the venues.
- Spectator, OF, media, and workforce care includes mobile response teams that can respond to any location in the venue; first aid services; and limited emergency/primary care services in the spectator medical station.
- Ambulance response should always be available at the venues and dedicated on-site ambulances should be scheduled during operational hours of the venues.
- If additional medical services are needed, patients will be transported via ambulance or non-emergency vehicle to the appropriate medical facility for definitive care. Medical standards of practice and local regulatory guidelines determine when ambulance transport is appropriate.

**Village Medical Services**

✕

Both the NOC and the OCOG medical teams provide medical care in the Olympic Village.

- The OCOG should provide each NOC with medical space for their team doctors and other NOC health professionals to provide general and sports medicine services to their delegation. Basic furnishings should be provided in this space.
- A 24-hour, multi-disciplinary polyclinic is required for the athlete's village to provide comprehensive medical care to the athletes and officials. The polyclinic will be staffed with doctors, nurses, and specialists to provide emergency/primary care/sports medicine/and specialty medical services.

Further information can be found in the Technical Manual on Olympic Village.

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# 1.1 Scope of Medical Coverage, Continued

**Community-based Medical Services**

While the OCOG is directly responsible for medical services provided within Olympic venues, OCOG Medical Services must also coordinate with community-based health services to ensure a seamless delivery of care. These services are outlined further in this manual, but in general they will include:

### Olympic Family Hospitals

Should be identified prior to Games-time so that hospital staff will be prepared to facilitate Olympic-related admissions.

### Medical Transport

Includes air and ground ambulances as well as non-emergency medical transport. Some of these resources will be dedicated to the venues during Games-time and some will respond from the community.

### Community-based Ambulatory Clinics

Should be available to treat international guests and the workforce who need services that are not available at the venues. In some instances, resources available at community-based ambulatory clinics may augment the services provided for the athletes at the village polyclinic.

### Public Health and Hygiene Services

Should include health education and promotion; illness and injury prevention; health surveillance; and response to health risks including communicable disease, food-borne illnesses, and exposure to biologic or chemical agents.

### Disaster Planning

Generally not the sole responsibility of the OCOG; rather, the OCOG (including Medical Services) will participate in disaster response planning with local, regional, and national disaster response agencies.

# 1.2 Chief Medical Officer

**Role of Chief Medical Officer**

The Chief Medical Officer (CMO) is the director of the Medical Services within the OCOG, and is responsible for all aspects of Medical Services.

### Appointment and Attributes

The Chief Medical Officer (CMO) should be appointed as early as possible, and no later than the previous edition of the Olympic Games (Summer or Winter) as applicable. This position may be part-time at the early stage but should be full-time no later than 8 months prior to the Games.

The CMO should have the following attributes:

- Come from the medical field and have a very good sense of organisation
- Be at least fluent in English
- Good notions of the current medical system existing in his country
- Good contact with the National and local Public Health Authorities

The CMO will organise the requirements for Medical Services as detailed in this manual for the OCOG, whilst taking into consideration local specificities of the Host City or region.

### Relation with IOC Medical Commission

The CMO is the interlocutor with the IOC Medical Commission on all Medical Service issues. To this effect, the CMO becomes a member of the IOC Medical Commission for the duration of his mandate, and will therefore have to take part in the 2 preceding editions of the Olympic Games as an active member of the IOC Medical Commission.

The CMO should be able to provide IOC Medical Commission with progress reports on a regular basis. The IOC Medical Director will work closely with OCOG Medical Services to provide guidance in the planning and delivery of the OCOG Medical Services Programme. During the preparation of the Games, the CMO will be in constant communication with the IOC Medical Director.

# 1.3 Insurance

**Introduction**

Medical insurance and professional liability insurance should be provided by the OCOG. The structure of the host country's public health programme and the liability of health care providers should be considered in the development of the OCOG's insurance programme.

**Obligation of Insurance**

△ ✕

The OCOG shall secure and maintain, well in advance of the Opening Ceremony of the Games and for some time after the Closing Ceremony of the Paralympic Games, at its expense, adequate insurance coverage in respect of all risks associated with the planning, organizing and staging of the Games. Such risks include, without limitation:

- Third party risks in order to cover all such third parties against, without limitation, bodily injury property damage, or purely financial risks including professional liability
- Accident and medical health insurance, including repatriation

The Games Insurance programme and the extent and level of coverage shall be subject to the prior written approval of the IOC. This shall not relieve the City, the NOC or OCOG of their responsibilities. See the Technical Manual on Other Olympic Games Matters for more information on Insurance.

However, the OCOG is not required to provide professional liability insurance for the NOC health care providers and the OCOG does not accept liability for the care provided by the NOC medical teams. Each NOC is required to make its own arrangements for professional liability insurance.

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# 1.3 Insurance, Continued

**Medical Insurance**

The medical insurance programme will cover individuals in the following accreditation categories:

| | |
|---|---|
| **IOC** | IOC member |
| **IF** | IF President and Secretary General |
| **NOC** | NOC President and Secretary General |
| **TOP** | TOP sponsor executive |
| **OC** | Future OCOG President and Director General |
| **G** | Dignitary, high ranking official, guest |
| **Gi** | Guest and entourage to G guest |
| **Gt** | IF and NOC guest |
| **B** | IOC commission member, staff, IF executive, sponsor project mgr. |
| **J** | IF technical official |
| **Aa** | Athlete |
| **Ac** | Chef de Mission |
| **Ao** | Team official |
| | All categories found within a venue. |

**Coverage**

The medical insurance programme should provide at no cost to the Olympic Family members but is only required to cover acute and emergent illnesses and injuries.

The coverage period typically begins with the pre-opening of the Olympic village and ends with the closing of the Paralympic Village. The host country may or may not have a public health care system available to international visitors. Outside the defined period of medical coverage, it may be advisable for the OCOG to recommend that all members of the Olympic Family carry private health insurance, including coverage for ambulance transport and hospitalisation.

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# 1.3 Insurance, Continued

**Repatriation**

The OCOG should provide, free of charge, a repatriation process for those members of the Olympic Family designated above, such that:

- In the event that a member of the Olympic Family requires medical repatriation, free transport with the necessary accompanying medical personnel should be provided.
- In the event of death, the repatriation process should cover the cost of transporting the body home. All arrangements in this respect should be handled by the OCOG.

**Professional Liability Insurance**

The OCOG should ensure that all members of the Medical Services clinical team (whether volunteer, contractor, and/or OCOG staff) are covered by professional liability insurance. This insurance may be provided by the OCOG, the individual health care provider, the health care providers' employers, the government, or other responsible agency. The amount of coverage must be commensurate with the risks associated in providing the Medical Programme as described herein.

The OCOG is not required to provide professional liability insurance for the NOC health care providers and the OCOG does not accept liability for the care provided by the NOC medical teams. Each NOC should make its own arrangements for professional liability insurance.

# 1.4 Right to Practice

**Introduction**

The OCOG should ensure that no regulatory issues will prevent or inappropriately limit the ability for the NOCs' medical teams to provide care to their delegation members. In addition, the OCOG should ensure the appropriate "right to practice" for the entire medical staff it recruits for its medical teams at the venues and Village.

**OCOG Medical Team**

The medical community of the host city may not have the professional resources to staff the entire OCOG Medical Programme. Since the OCOG may have to recruit medical specialists from outside of the local area, it should ensure that the professional licenses of these "recruits" allow them to fulfil their duties on the OCOG medical team. If existing professional licenses are not recognized by the local health authority, provisional or temporary licenses (or similar certification) may need to be issued. Because addressing these requirements may require legislative action, it is extremely important that these regulatory issues be reviewed well in advance of the Games period (i.e. several years in advance), to allow adequate time for governmental and/or legislative processes.

**NOC Medical Team**

The physicians and non-physician health professionals that travel with the National Olympic Committees (NOCs) should be legally allowed to care for the members of their respective delegations. All relevant laws should be reviewed – and in some cases, revised – to ensure that the NOC medical staff will be able to carry out their duties within the legal parameters imposed.

There will likely be certain limitations for the NOC medical teams. These should be reviewed with the IOC Medical Director who can provide counsel regarding whether such limitations are reasonable or whether they should be revised. Generally, the NOC doctors should be allowed to:

- Treat the members of their delegations in the NOC medical space provided in the athletes' village(s), at the venues, and at other housing sites for delegation members that are not staying in the athletes' village
- Write prescriptions for non-controlled pharmaceuticals, to be filled in the polyclinic pharmacy
- Order certain services or diagnostic procedures in the polyclinics
- Accompany delegation members to the polyclinic, Olympic Family hospitals, and/or local ambulatory clinics and actively consult in the care of these patients

Continued on next page

# 1.4 Right to Practice, Continued

**NOC Medical Team** (continued)

Limitations of NOC physicians' right to practice should be clearly communicated to them. Such limitations may include:

- No authority to admit patients to the hospital
- No right to participate in hands-on care of the patient in the polyclinic or hospital

In the care of athletes on the field of play, OCOG Medical Services should clearly define expectations and legal limits associated with first response to an injured athlete. These expectations and legal limits should be reviewed with the NOC medical teams prior to competitions.

**Registration of NOC Medical Team**

The OCOG should coordinate the registration of the NOC medical staff under the authority of the health ministry or other governmental health-licensing agency. The process may include governmental review of licensure documents, which can be a lengthy process so the NOC physician registration process should be initiated with adequate lead-time.

The NOC medical teams include physicians and may also include non-physician health care professionals such as physio-therapists. The OCOG and local licensing agency must determine which categories of health professionals must register, and which might work under the direct responsibility of the registered NOC physicians.
The OCOG medical team should work closely with the NOC Services function, which will facilitate communication of the registration process with the NOC chefs de mission and NOC Chief Medical Officers.

# 2.0 → Medical Care - Athletes

## Executive Summary

**Introduction**

Participating athletes will have to stay quite a long time away from their home country. Due to the intensive physical activity relating to training and the stress due to the proximity of such an important event in the life of the athlete, Olympic athletes should be looked after appropriately, and medical services should be ready to react quickly as the Games period is short and the issues are major. Therefore, medical services both from the athlete's own delegation and from the OCOG should provide all the assistance needed. This chapter outlines the responsibility to provide medical care to the athletes.

**Contents**

This chapter contains the following topics:

| Topic |
|---|
| 2.1 Overview |
| 2.2 Athlete Care - Venues |
| 2.3 Athlete Care – Olympic Village |
| 2.4 Considerations for Paralympic Athlete Care |
| 2.5 Athlete Care - Olympic Family Hospital |

# 2.1 Overview

**Introduction**

The IOC Medical Commission and the International Federation of Sports Medicine (FIMS) have published ethical guidelines for physicians and other health professionals that are involved in the care of athletes. Information on these organisations can be accessed via the relevant websites.

As stated in the FIMS Code of Ethics, (23 September 1997) or latest relevant document:

> 2. Ethics in Sports Medicine:
> Physicians who care for athletes of all ages have an ethical obligation to understand the specific physical, mental and emotional demands of physical activity, exercise and sports training.

This obligation requires the OCOG medical team to select the appropriate medical professionals and ensure that they have the necessary specialized knowledge and skill to effectively work with the elite athletes participating in those sports in the Games programme. The OCOG Medical Programme should provide the necessary facilities, equipment, supplies and procedures to support optimal care to the athletes. The OCOG's medical team is encouraged to contact the medical directors of those International Federations of Sport (IFs) that will participate in the Games programme to learn more about the unique risks and medical needs of the athletes.

A complete listing of the IFs for both summer and winter Games can be found in the Technical Manual on Sport.

**Access to Services**

Medical care should be provided at the competition and training venues, the athletes' village and at the Olympic hospital. Should the athletes develop a need for care while outside these locations, the Medical Programme must have provisions to transport athletes to the nearest appropriate health care facility.

Continued on next page

# 2.1 Overview, Continued

**Communication Regarding Athlete Medical Status**

The NOCs will have made provisions for their athletes to be placed under the care of the NOC team doctors; however, the OCOG should respect confidentiality of all patients in their care. Only with the athlete's permission should the OCOG medical staff consult with and/or update the NOC team doctors regarding medical care provided to the athletes. If the athlete's family is present, the same responsibilities apply.

In the case of significant illness or injury of an athlete, the VMO in consultation with the OCOG's Chief Medical Officer may determine that the OCOG main operations centre (MOC) should be notified. This notification should protect confidentiality issues, but if a medical situation occurs that is likely going to get media attention or require notification of the athlete's family or NOC, the MOC should be informed.

The IOC Medical Director/IPC Medical & Scientific Director will also need to be kept informed about significant illness or injury of athletes.

In addition to these "real-time" notification protocols, OCOG medical services will need to prepare after-action reports summarizing medical care provided to the athletes and to other constituent groups.

**Doping Control Considerations**

Competing athletes are subject to in-competition doping controls throughout the Olympic period. A positive test can result in the loss of medals and sanctions that can end a career. When an athlete is being treated by the OCOG's medical team, it should be ensured that prohibited medications are not inadvertently administered. For this reason, it is imperative that all medical personnel involved in the treatment of athletes be educated about doping control issues, and know where to access accurate information regarding the status of medications. The health of the athlete is always the primary consideration and prohibited medications may be deemed a necessary component of a treatment plan, however, when treatment options permit, administration of prohibited or controlled substances should be avoided.

**Reporting**

If a competing athlete is given a prohibited or restricted substance, the treating physician should complete the "International Olympic Committee Medical Commission Notification of the Therapeutic use of a Prohibited Substance" form, or applicable form made available by the IPC for the Paralympic Games. This form must be signed by the athlete, NOC team doctor, and treating physician and then forwarded to the IOC Medical Commission offices.

# 2.2 Athlete Care - Venues

**Introduction**

Athlete medical services should be provided at competition, training, and non-competition venues and the medical programmes at each of these locations should be appropriately tailored to meet the unique needs at that venue. The venue medical team should have expert knowledge of sports medicine and IF medical requirements for the specific sport discipline at their venue.

Prior to competition, the plan for athlete care should be reviewed with the NOC medical team at each venue. The Venue Medical Officer (VMO) should plan to hold a meeting with the NOC physicians at the beginning of official training at his/her venue.

**Days and Hours of Service** △

Athlete medical services must be provided on all days of official training and competition, beginning one hour before training or competition begins.

**Field of Play (FOP)**

The medical staffing and equipment needs will vary for each venue's FOP. Medical Services should work closely with the Sport function and should consult medical experts that are familiar with elite athlete medical needs in each sport discipline.

The medical FOP response plan should address life-threatening injuries as well as those less serious. The OCOG should have ready-response and should focus on safe and expedient evacuation of the athlete from the FOP so that more definitive medical assessment and treatment can be provided in a safer, more comfortable location. FOP medical staff, equipment, and supplies should be strategically located to ensure a prompt response but not interfere with competition or training. Competition rules for each sport should be addressed when developing emergency response protocols to ensure the safety of everyone on the FOP and allow continued competition when possible. Certain sports will require the service of on-site specialists (e.g. on-site emergency dentists and emergency dental supplies for ice hockey).

Continued on next page

# 2.2 Athlete Care - Venues, Continued

**Field of Play (FOP)** (Continued)

FOP communication between competition management, OCOG medical teams, and Emergency Medical Services (EMS) responders should be planned and tested in advance of Games-time. Radio protocols should be established and enforced. The OCOG's Venue Communication Centres (VCC) managers should be consulted in this planning.

**Athlete Medical Station**

The athlete medical station at each competition venue should provide services ranging from limited sports medicine and primary care services to initial care of life-threatening conditions. NOC physicians and/or physio-therapists should be allowed to collaborate in the treatment of athletes at the venue athlete medical stations. In life-threatening instances, the first response, assessment, and treatment should be the sole responsibility of the OCOG medical team and EMS responders.

### Access

The athlete medical station provides services to athletes and officials with access to the field of play areas. In some cases, if athletes are staying near the venue rather than in the Olympic Village, they may seek medical care at the venue medical station even on days in which they are not competing or training.

### Staffing

The station should be staffed by a physician and nurse and may include other support staff. In addition to the provision of medical care, staff duties will include documentation of care; operational and clinical reporting; management of equipment and supplies; communication; and base of operations for the venue's FOP medical teams. Staffing numbers should support the volume of anticipated medical encounters based on review of previous Games Medical Programme. This data is available in the "Transfer of Knowledge" reports.

### Facility and Location

The facility and its location can vary depending on the sport and the venue design. The station may utilize existing indoor space, a tent, or other temporary structure such as a modular trailer. The main considerations are that the structure can be secured, temperature controlled, and allow space for the necessary services to be provided. The location of the facility should be based on proximity to the FOP, access by EMS vehicles, and privacy from media and spectators. The space should allow for examination and treatment areas, a waiting area, toilet and hand-washing facilities; and workspace for the medical volunteers. Privacy should be addressed with walls, space, screens or curtains.

Continued on next page

# 2.2 Athlete Care - Venues, Continued

**Referral for Definitive Care**

Athletes may be transferred to the Polyclinic for more comprehensive medical assessment and care. If clinically necessary, athletes may be transferred to an Olympic Family Hospital. The venue medical team will assist with necessary arrangements for such referrals including transport and transfer of appropriate clinical history.

**Emergency Medical Services (EMS)**

On-site ground ambulances should be available during scheduled competition and official training periods at the venues. Certain venues may require the presence of on-site air ambulances (med-evac helicopters), either by requirement of the relevant IFs or as deemed necessary for the safe and timely transport of acutely ill or injured patients.

The operational procedures involved in activation of EMS should be developed and agreed upon by the OCOG's Medical Services function and community-based EMS management. It is important for community-based EMS to understand the access-control issues associated with an Olympic Games and it is equally important for the OCOG to recognize and respect the safe operational procedures that have been developed from the expert experience of the EMS system. In responding to athlete injuries, EMS should allow the OCOG medical team to respond and assess an injured athlete prior to activation of EMS response.

Continued on next page

# 2.2 Athlete Care - Venues, Continued

**Equipment & Supplies**

The equipment and supply requirements can vary depending on the sport, the venue, and the distance from the Olympic Village. For venues that are more distant from the Olympic Village, the OCOG may wish to consider broader medical service capabilities at the venue. On-site radiology and tele-medicine capabilities are not a requirement, per se, but the OCOG may wish to consider such technologies in remote venue locations. Minimum requirements include:

- Basic and advanced life support equipment. BLS and ALS equipment should include defibrillators, strategically located for quick response
- Evacuation equipment for immobilization of the athlete, transport from the FOP, and transport from the venue
- Orthopaedic soft goods, splinting materials, bandaging, suture kits, etc. that may be required on-site so the athlete can be treated and allowed to return to competition, if clinically appropriate
- First aid supplies
- Ice
- Sealed nutritious beverages, water and snacks
- Medications for on-site administration to the athlete which may include supplies for intravenous hydration and/or administration of intravenous medications
    - Pharmacy services or dispensing of medications is not required at venues
    - In the case of "prohibited" or "restricted" medications (with regard to Doping Controls) the venue medical team must follow strict procedures to ensure that such medications are not *inadvertently* administered to an athlete. Such procedures should include:
        - Labelling of such medications
        - Labelling and locking the drawer/box where such restricted medications are stored
        - Completing International Olympic Committee Medical Commission Notification of the Therapeutic Use of a Prohibited Substance

OCOG Medical Services is encouraged to review medical equipment and supply lists from previous Games. These should be available in the Games Knowledge Reports found on the Olympic Games Knowledge Extranet.

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# 2.2 Athlete Care - Venues, Continued

**Athlete Prep Areas**

Athlete prep areas may include locker rooms, work out areas, or tents in which the athletes prepare for competition. The OCOG is not expected to provide medical staffing in these athlete prep areas, but it may be helpful and appropriate to provide training tables, ice, taping supplies, or other items. The IOC Medical Director and/or the OCOG's sport directors can provide advice on supporting athlete prep areas.

**Medical Transport**

On-site ambulances are generally required at all venues during periods of operation. In addition, IFs may dictate specific air- or ground- ambulance requirements for certain sport disciplines. Transport routes, weather conditions, and security considerations should be reviewed in developing medical transport plans.

If an athlete should be transported for definitive care or additional diagnostic testing, the VMO or his/her designee will determine whether Emergency Medical Services, (i.e. EMS ambulance) transport is required, in accordance with medical indications and standards of care. In non-acute circumstances, the OCOG should make arrangements for non-emergency vehicles to be available to transport the athlete and accompanying persons.

**Communication**

Communication procedures should be established for intra-venue communications, and communication with the OCOG's medical headquarters (MHQ); the polyclinic; community health agencies including EMS dispatch, the public health department, Olympic hospitals; and the OCOG's main operations centre (MOC). There should also be communication with the NOCs in the event of a significant athlete illness or injury.

Communications equipment may include telephones (land-lines and/or cellular phones), 2-way radios, OCOG intranet, and fax. It is important to develop communication plans for routine sharing of information and for emergency notification of relevant parties. The OCOG medical team cannot develop their communications plans independently; rather, the OCOG's Venue Operations and Venue Communications functions should be involved, as well as the community health network. When and where possible, existing communication protocols should be utilized, to minimize training requirements and reduce the chance of errors.

**Non-Competition Venues**

The athletes may need access to medical care at non-competition venues including the Opening/Closing Ceremonies, Medals Ceremonies, and while in transit. These venues may not require a dedicated athlete medical station, but medical plans should allow for effective treatment and privacy for the athlete, if needed. The athlete can be transferred to the village polyclinic for definitive care.

# 2.3 Athlete Care – Olympic Village

**Introduction**
✕

Both the NOC medical teams and the OCOG medical team provide medical care in the Olympic Village. The majority of athletes prefer to be treated by their own NOC team doctors rather than use OCOG facilities and medical staff.
This chapter will cover the Polyclinic (facility and services), NOC Medical Services, and medical Items for the Rate Card.

Further information can be found in the Technical Manual on Olympic Village.

**Olympic Village Obligations**
△

- The OCOG must provide each NOC with medical space for the team doctors and other health professionals to provide general and sports medicine services to their delegation. Basic furnishings will be provided in this space.
- A 24 hour, multi-disciplinary polyclinic must be established in the athlete's village to provide for comprehensive care of the athletes and officials. The polyclinic should be staffed with doctors, nurses, and specialists to provide emergency / primary / sports medicine / and specialty medical services.
- EMS services (on-site ambulances) must be available 24 hours a day during the operational period of the Village.

# 2.3.1 Polyclinic

**Introduction**
**Reference**
✕

As described in the Technical Manual on Olympic Village, many small delegations will be without any medical support or perhaps restricted to massage staff. Other NOCs may have partial medical support. The OCOG polyclinic services will thus be the sole or practical source of medical and paramedical assistance to such teams. In addition, emergency medical assistance and ancillary medical services may be required by athletes from all countries, even those with full medical teams.

The Village Polyclinic is a multi-faceted health care centre staffed and equipped to provide a multi-disciplinary service to residents of the Olympic Village as required. In addition to a primary, specialty, and sports medicine services, the clinic should include a physician with public health and hygiene expertise to advise the OCOG and team physicians on health and hygiene aspects of the Olympic Village, venues, and local environment.

Medical services at the polyclinic are provided primarily for the athletes as part of a comprehensive healthcare programme. Polyclinic services may be provided to other members of the NOC delegation or Olympic Family as resources permit, but such expanded access should not guide capacity planning for the polyclinic.

**Facility Space and Location**

The polyclinic should be located in the Residential Zone of the Village. The surface areas recommended are as follows:

- Summer: 2700 $m^2$
- Winter Games: 800 $m^2$

These space requirements represent a minimum standard. The OCOG's Village and Medical Services functions must determine the size and structure of the facility to be utilized. The availability of certain technologies may indicate additional space requirements (e.g. a pad for mobile Magnetic Resonance Imaging trailer). Planning for effective logistics (patient flow and staff operations) in the polyclinic should be coupled with efficient use of space to mitigate undue expense.

Continued on next page

# 2.3.1 Polyclinic, Continued

**Primary Care and Emergency Services**

Services to be provided include:

- Diagnosis and treatment of routine medical problems
- Consulting physicians on call for complicated medical problems
- Ambulance (or non-emergency vehicles) to transport patients with complicated cases to the Olympic Hospital or to designated community-based medical facilities prepared to treat Olympic athletes as an extension of the polyclinic.

In addition, a full range of services by medical and surgical specialists and sub-specialists should be organized by the OCOG for use by the athletes and officials resident in the Olympic Village. Close cooperation between team doctors and polyclinic medical staff should be maintained.

**Sports Medicine and Physiotherapy**

Services to be provided include:

- Diagnosis and treatment of uncomplicated musculoskeletal problems
- Minor trauma requiring suturing and dressings
- Prescriptions of medical therapy

A fully equipment physiotherapy facility with a wide range of therapeutic equipment should be provided, including:

- Ice
- Diadynamic electrotherapy
- Interferential therapy
- Short wave diathermyultrasound
- Galvanic stimulation
- Transcutaneous nerve stimulators
- Whirlpools
- Traction tables and underwater massage

Experienced sports physiotherapists are essential. Suitable rehabilitative exercise equipment and hydrotherapy facilities should be organized. Physiotherapy service areas should be separated from medical treatment areas.

**Podology**

Podiatry (podology) services should be available for acute problems only.

Continued on next page

# 2.3.1 Polyclinic, Continued

**Eye Care**

Ophthalmologic and optometric services should be available only on an emergency basis. Services should include:

- Initial diagnosis and treatment of eye injuries and eye diseases
- Replacement of eye glasses and contact lenses

**Dental Care**

Dental care shall be available only on an emergency basis. Services should include:

- Treatment of broken or injured teeth
- Fillings
- Replacement of caps
- Limited oral surgery

**Pharmacy**

Pharmacy services should be available for dispensing medications identified in the Drug Formulary Guide. The formulary should be provided to each NOC's team physician prior to their arrival. Special considerations of the pharmacy programme include:

- Prescription of barbiturates and narcotics, as well as other controlled substances, by the NOC's team physician should be countersigned by an OCOG polyclinic physician if required by the host country's local laws.
- The OCOG medical team should ensure safety provisions so medications that are prohibited or controlled as part of the Doping Control Programme are not inadvertently prescribed or administered to athletes. This requires safety mechanisms for the prescription pads (counter-signature lines for the athlete an d the NOC team physician), as well as physical safety mechanisms established to control access to prohibited or controlled medications which should be guaranteed not only in the polyclinic pharmacy, but also in the venue medical stations.

**Radiological Services**

Radiological services should consist of plain film examination or digitised radiography (without contrast media) and diagnostic ultrasound. Patients requiring more complex procedures shall be referred to a hospital.

**Laboratory Services**

The polyclinic should designate a reference laboratory and courier system to provide quick lab results. It should consider certain point-of-care or on-site testing for routine lab tests.

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# 2.3.1 Polyclinic, Continued

**Emergency Medical Services**

On-site staffed ambulances should be scheduled 24 hours a day during the operation period of the Village. Communication protocols must be established for EMS response to all areas of the Village, not just calls from the polyclinic. The polyclinic medical team should be in direct communication with the ambulance team in the event a resident or visitor to the Village must be transported to the hospital.

**Medical Records**

OCOG Medical Services should ensure documentation of medical care that is consistent with standards in the local health care community, which supports effective clinical communication between multiple care-givers for a seamless care delivery process for those athletes that may be seen more than once or at multiple Olympic medical facilities.

**Office for the IOC Medical Commission**

A room, located within the polyclinic, should be made available for the IOC Medical Commission to use as an office. The office should be equipped with a computer, internet and telephone access; a desk or table and chairs; a printer/copier; and a locking cabinet.

**Village Doping Control Station**

The OCOG's Doping Control Programme will require a doping control station in or near the Polyclinic, which is described in the Doping Control part of this manual.

**Biomedical Technologies**

OCOG Medical Services should ensure safety of the diagnostic and therapeutic technologies used at the polyclinic. This will include safety performance testing of equipment prior to and during the operational period of the venue. Performance testing, documentation, and repairs of clinical equipment should meet current standards of the local medical community.

# 2.3.2 NOC Medical Services

**Introduction**

Most Olympic teams will bring complete or near complete medical or paramedical staff, drugs and equipment for use in the care of the athletes and other delegation members. The OCOG should provide adequate medical facilities for such teams.

This is described in more details in the section on Health Regulations and Entry Rules in the Country in this manual, for additional information related to the importation of medical equipment and supplies.

**Allocation of NOC Medical Space**

As detailed in the Technical Manual on Olympic Village, medical space (Doctors' Rooms and Massage Rooms) should be within or immediately adjacent to sleeping quarters, according to this scale:

| Delegation (Size) | Doctors' Rooms ($m^2$) | Massage Rooms |
|---|---|---|
| 1-24 | 0 | 1 |
| 25-50 | 1 | 1 |
| 51-100 | 2 | 2 |
| 101-200 | 2 | 3 |
| 201-300 | 3 | 4 |
| 301-450 | 3 | 4 |
| 451-600 | 4 | 5 |
| 600+ | 5 | 5 |

The basic NOC medical centres in the Village should have adequate space and lighting, and should be temperature controlled with sufficient electrical sockets (power points). It may be necessary for NOCs with less than 25 athletes to share medical space with up to 3 other NOCs.

The OCOG's Olympic Village function will have responsibility for allocation of space, and the Medical Services function will provide consultation relating to specifications for examination room furnishings and equipment (see next section).

Continued on next page

# 2.3.2 NOC Medical Services, Continued

**Furnishings & Equipment**

Each Doctor's Room and Massage Room should be equipped as follows:

### Doctor's Room

| | |
|---|---|
| Desk with drawers | Wash basin |
| Chairs | Pillows, blankets, and towels |
| Disposable paper cups | Disposable covers |
| Small refrigerator/freezer | Trolley |
| Storage unit for ice | Examination couch (table) |
| Waste baskets - standard | Locking drug cabinet |
| Waste receptacle - hazardous | Sharps disposable container |

### Massage Room

| | |
|---|---|
| Desk with drawers | Wash basin |
| Chairs | Pillows and blankets |
| Disposable paper cups | Towels |
| Waste baskets | Disposable covers |
| Storage unit for ice | Trolley |
| Large cupboard to store tapes, bandages, dressings, etc. | |

The medical space should be provided with laundry services for towels, linens, and blankets; housekeeping and waste removal; and safe handling of medical waste and sharps. Ice making facilities to supply sufficient ice to the Olympic Village (as well as at competition sites) must be available.

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# 2.3.2 NOC Medical Services, Continued

**Meetings & Communication with NOC Medical Team**

The OCOG medical team should plan for several opportunities to communicate with the NOC medical teams. These include:

- NOC Services will facilitate written communication with the teams' Chefs de Mission and Chief Medical Officers during the times leading up to the Games. Information can be exchanged, including advanced registration of the NOC physicians and paramedical staff. During pre-Games visits, NOC Services may facilitate meetings between the OCOG medical team and the NOC.
- Upon arrival of the NOCs at the village, the Chefs de Mission will meet with NOC Services. Medical Services should prepare a packet for the NOCs, to include:

  - An overview of the Medical Programme
  - One copy each of the Medical Guide, Technical Doping control procedures, and Drug Formulary
  - An invitation to the NOC Team Doctors meeting (see below)
  - A form to be completed by the NOC listing all NOC medical staff and their local contact information (i.e. cell phone number)

- The Chef will be responsible for forwarding the packet to the NOCs' Chief Medical Officer and ensuring that the NOC medical team contact information is submitted to the OCOG's Chief Medical Officer.
- The NOC Team Doctors meeting should be held in the Village on the afternoon before Opening Ceremonies. The agenda will be coordinated by the IOC medical director, the OCOG's Chief Medical Officer, and the OCOG's doping control manager. All working members of the IOC Medical Commission will attend and arrangements must be made for audio-visual equipment and simultaneous interpretation services. Following the NOC Team Doctors meeting, it is recommended to host a reception for the NOC medical staff to meet the OCOG's core medical operations team and venue medical officers.

# 2.3.3 Medical Items for Rate Card

**Introduction**

The OCOG should develop a "Rate Card" catalogue to provide certain equipment, supplies, and services to various Olympic constituent groups. All items and services should be reasonably priced and may be available for purchase or lease. NOC Services will facilitate the NOC's in accessing the Rate Card Programme.

**Medical Equipment and Supplies for Rate Card**

The OCOG should provide the NOC medical teams with the ability to acquire limited medical supplies and equipment for treatment of their delegations. Generally, the NOCs will bring all necessary equipment and supplies, but in certain instances they may choose to acquire some equipment and supplies locally. As described in the preceding section (NOC Medical Space), the OCOG should provide limited furnishings and equipment for this space. If the NOC desires additional quantities of such furnishings and/or equipment, these can be provided through the Rate Card. In addition, certain physio-therapy should be included.

The required items for the Rate Card may vary from Games to Games. It is recommended that the OCOG Medical Services Function survey the NOCs to assess their need for Rate Card items. This survey should occur approximately two years prior to the Games period to allow for sourcing of the items. In past Games, Rate Card items for the NOC medical teams have included:

| | |
|---|---|
| Chilling Unit | For storage of cold packs and ice |
| Heating Unit | For heating hot packs (hydrocullator) |
| Massage / Treatment Tables | Portable tables |
| TENS Units | Transcutaneous therapies |
| Traction Devices | Portable devices |
| Ultrasound | Portable units |
| Electro-Stimulation | For EMG therapies / biofeedback |

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# 2.3.3 Medical Items for Rate Card, Continued

**Procurement of Rate Card Items**

The responsibility of the OCOG's Medical Services Function is to determine what medical equipment and supplies are to be included in the Rate Card. Medical Services may also have responsibility to work with suppliers to make arrangements for the equipment and/or supplies to be purchased or leased.

The OCOG's NOC Services Function will work directly with the NOCs to facilitate orders, pick-up and return of items, and billing issues.

# 2.3.4 Nutrition

**Introduction**

The Nutrition Sub Function in the Olympic village should take into consideration the special needs of high performance athletes as well as national and religious habits and traditions. It is essential that the very highest standards of hygiene be adhered to at all times.

The menu should be prepared following consultation with relevant sport nutritional specialists. Packed lunches should be provided up prior request by the Chef de Mission, or his designate. The quality of these packed lunches should be controlled following consultation with sport nutritional specialists.

OCOG Medical Services, in consultation to the OCOG's Village Services and Food and Beverage Sub Functions should ensure that the appropriate nutritional analysis occurs. The public health authorities must be involved in planning for food security as well as proper hygiene, not only in the food preparation activities, but also in relation to food handling throughout the supply channel.

The IOC, together with authors Ronald J. Maughan and Louise Burke, has published a handbook, Sports Nutrition: Olympic Handbook of Sports Medicine and Science, which can be consulted for additional information on sports nutrition.

More information can be found in the Technical Manual on Olympic Village and section on Control of Air, Water, and Food Supply in this manual.

# 2.4 Considerations for Paralympic Athlete Care

**Introduction**

- IPC

The Medical Programme for athlete care should be consistent with that provided for the Olympic athletes. Some of the medical facilities or staffing may be reduced, but only with respect to the lesser number of participating athletes – NOT - with respect to scope of services. This section will address, generally, the special preparations and services that should be developed for the Paralympic athletes.

The conditions that are most often observed in Paralympic athletes include cerebral palsy, paralysis, amputations, visual impairments, and certain intellectual disabilities. It is important for the OCOG medical team to understand that treating *elite athletes* with these disabilities can be very different than providing treatment to patients in typical physical medicine and rehabilitation or physiatrist practices. The athletes are often experts with regard to their disabilities and how they manage their health so they should be active participants in determining treatment options.

During the summer Games the OCOG should be aware that athletes with high spinal cord lesions, and hence reduced temperature regulation, have a greater risk of dehydration even if the temperatures are not extreme.

**Field of Play (FOP)**

When Paralympic athletes are competing with adaptive equipment, the FOP medical team must be sure they have experience in extricating athletes from such adaptive equipment (e.g. mono-ski shells). In assessment of injuries, the medical team should consider those athletes that are insensate. There are certain clinical conditions for which Paralympic athletes are at risk (e.g. autonomic dysreflexia, skin breakdown). It is important that the OCOG recruit medical personnel that are experienced in providing care to athletes with disabilities. In cases where less experienced medical personnel have been recruited, it is the responsibility of the OCOG to provide relevant training (didactic and practical).

**Athlete Medical Stations**

When the athlete medical stations are designed for the Olympics, they should have been made fully accessible, with ramps and doors that can accommodate wheelchairs and/or stretchers. If examination tables cannot be adjusted for height, transfer assistance will be required for some athletes.

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# 2.4 Considerations for Paralympic Athlete Care,
Continued

**Equipment and Supplies**

The equipment and supply lists will be similar for both Games, however, the Paralympic inventory for venue medical stations and the polyclinic should include an adequate stock of urinary catheterization supplies, advanced wound and skin care products, bowel programme supplies, pressure-relieving wheelchair cushions and liners, etc.

The physiotherapy area in the polyclinic should include high-low exam tables and a wheelchair accessible universal gym set-up.

**Polyclinic**

### Facility

The polyclinic facility should be designed for accessibility. In addition:

- The OCOG should provide adequate office space for the IPC medical staff that will liaise with the polyclinic medical team and NPC doctors/physiotherapists; review injury and illness data; and manage the therapeutic use exemption process.
- Space should be allocated for doping control in or near the polyclinic, as described in the part on Doping Control in this manual.

### Staffing

During the Paralympic operational periods of the polyclinic, the staffing should at all times include medical personnel experienced in treating athletes with disabilities.

**Related Paralympic Services**

### Prosthetic, Orthotic and Wheelchair Repair Services

The OCOG's Village Services function should provide a service centre for prosthetic, and orthotic and wheelchair repair services. Limited services should also be available at the venues. Medical Services should be acquainted with the location and services provided.

### Classification

The OCOG's Sport and Village Services functions will work together to provide space, equipment, and volunteers to support the classification process for the Paralympic athletes. OCOG Medical Services may be asked for assistance in procuring some of the clinical equipment required for the classification process, including ophthalmology equipment.

# 2.5 Athlete Care - Olympic Hospitals

**Introduction**

During the Games operational period, athletes and other members of the Olympic Family may require care that cannot be provided at the venue medical stations or the village polyclinic. For such circumstances, the OCOG must have set-up and duly prepared, a system of Olympic hospitals. Advanced preparations will include planning for security; language services; privacy from the media; facilitated admission and billing procedures; knowledge of doping controls; collaboration with NOC medical teams; and communication with the OCOG's medical team.

The selection of the Olympic Hospitals should take into consideration proximity to the venues and the village, as well as medical specialization of the hospital. Agreements should be established with these hospitals to ensure a) adequate planning and operational resources prior to and at the time of the Games and b) financial arrangements that will support the OCOG's obligation to provide free medical care to the athletes and Olympic Family members.

Each Olympic hospital should appoint a Hospital Olympic Liaison Officer (HOLO) and implement an Olympic planning team. The HOLO will be responsible to the OCOG's Chief Medical Officer, or his designate, for planning and Games-time operations as related to care of Olympic patients.

**Official Olympic Hospitals** △

Appropriately staffed and equipped hospitals shall be designated as official Olympic hospitals in which emergency medical and surgical services will be available free of charge to Olympic Family. OCOG shall sign an agreement with all Olympic Hospitals to ensure this service.

**Security**

High-profile patients such as Olympic athletes, dignitaries, heads of state, etcetera, may bring forth increased security risks. The hospitals should be able to ensure the safety and security of all patients in their care. The hospital's security department should consult with the public safety and OCOG security departments in reviewing/revising its security procedures and resources. This may include implementing additional surveillance and access-control procedures.

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# 2.5 Athlete Care - Olympic Hospitals, Continued

**Language Services**

In order to ensure optimal care of its patients, the hospital should make provisions for effective communication between the patient and medical staff. This may require a combination of on-site interpreters, on-call interpreters, and/or use of a telecommunications to access interpreters (i.e. a "Language Line Services" or similar). The OCOG's NOC Services function can assist by providing information about which countries will be participating in the Games; how large the delegations will be; and what languages are typically spoken in the represented countries.

In some instances, athletes or other Olympic Family members may have a representative from their delegation that can accompany them to the hospital and assist with language needs. If available, an assistant assigned by the OCOG's NOC Services; Language Services; or Olympic Family Services functions may be able to provide assistance at the hospital, however, these individuals may not have a good working knowledge of the medical environment or medical vocabulary.

**Public Relations and Media**

With thousands of journalists and broadcast media visiting the host city during the Games period, the hospitals must prepare effective public relations policies and procedures. High-profile patients; mass casualty incidents; significant episodes of communicable illness; or significant exposures to hazardous substances will increase media attention at the Hospitals. Existing public relations policies and procedures which ensure patient privacy while providing an appropriate level of information to the media should be reviewed, and revised if necessary. Where practicable, a proactive approach to providing information to the public will be helpful. Examples may include prepared press releases explaining hospital procedures for release of patient information, containment of communicable disease, and decontamination procedures.

The Olympic Hospital administration and public relations departments should stay in close communication with the OCOG's medical headquarters (MHQ) and main operations centre (MOC).

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# 2.5 Athlete Care - Olympic Hospitals, Continued

**Admissions, Billing, and Discharge Procedures**

The hospital staff involved in admission procedures must have clear guidelines to accurately identify the Olympic-related patients that are covered by the OCOG's obligation to provide free medical coverage. Communication with the OCOG's medical headquarters can be accomplished by the admission staff or the HOLO.

Once the patient's eligibility for the Olympic medical coverage is established, the billing procedures should be taken care of without undue hassle for the patient. Paperwork allowing release of information to the guarantor is recommended, as this will support the Olympic Games "Transfer of Knowledge" summary of Olympic patient care and related costs be submitted for review by future Olympic planners.

Upon discharge, the hospitals are asked to prepare a copy of the medical chart and related diagnostic tests directly to the patient. This proactive issue of the patient's medical chart will facilitate follow-up care that may be required upon the patient's return home.

**Communication with OCOG's Medical Headquarters**

The Olympic Hospitals and the OCOG's Medical Headquarters (MHQ) must stay in close communication regarding:

- Availability of open hospital beds
- Emergency transport of athlete or OF member to the hospital
- Non-emergency referral of athlete or OF member to the hospital
- Suspected public health concern (communicable illness, chemical or biological exposure, food borne illnesses, etc.)

The EMS ambulance system and/or public health agencies should be involved in the notification processes.

MHQ should facilitate communication with the appropriate members of the patient's delegation while ensuring that patient privacy rights are protected. OCOG Medical Services can facilitate this process by providing the Olympic Hospital with a list of the NOC Chief Medical Officers and their local cell phone numbers.

Continued on next page

# 2.5 Athlete Care - Olympic Hospitals, Continued

**Collaboration with NOC Medical Staff**

When an athlete needs treatment or diagnostic procedures that cannot be provided directly by their NOC's medical team or the OCOG medical staff, they will be referred to the Olympic hospital. With the permission of the athlete, the medical staffs at the hospital are asked to collaboratively consult with the NOC team doctor, and where practicable, to allow the NOC team doctor to accompany the patient for tests, treatments, or surgical procedures. The NOC team doctor should be able to provide medical history information as well as emotional support to the athlete.

**Doping Control Issues**

The hospital's medical staff must have a good understand of doping controls and access to the restricted or prohibited status of medications, and is outlined in the part on Doping Control in this manual.

# 3.0 → Medical Care - Spectator, Workforce & Media

## Executive Summary

**Introduction**

This chapter describes the medical care related to spectators, workforce and media.

**Overview**

Any individual, if physically present at the venue, should be served by the OCOG's Medical Programme. The venue "Spectator' medical team will serve the spectators, Olympic Family (OF), media, sponsors, and the venue workforce, including OCOG staff, volunteers, and contractors.

In determining the scope of services provided to this constituent group, the OCOG should consider proximity to community-based medical facilities; age and health status of the anticipated patient population; weather conditions; the venue's hours of operation; and any other risk-factors associated with the venue such as distance/elevation between the parking lots or transport drop-off locations and the venue entrances. In determining the scope of primary care, the OCOG should consider the benefit of treating minor injuries and illnesses of the workforce on-site, so that the worker can return to their duties.

During the Games period, the OCOG must work with community-based health care agencies to ensure that international guests and workforce members do not overwhelm the community-based hospitals and clinics. The hospitals and clinics located in close proximity of venues should be made aware of operational hours of those venues, so they can plan appropriately.

Continued on next page

# Executive Summary, Continued

**Days & Hours of Service**

Spectator medical services should be operational on all days when spectators will be present at the venues. Medical Staff should be in place at least one hour before "spectator load-in" begins and should plan to stay in position until 30 minutes after the spectators have left the venue. Venue management should be consulted in determining medical service coverage hours. When the OCOG is determining the dates of service for the Spectator Medical Programme, it should consider not only the dates and times that spectators will be present at the venues, but also workforce medical needs. This does not imply that the full spectator medical team is present when any workforce is on-site, however, some provisions should be available during venue preparations and after-hours periods. This should include availability of first aid supplies and workforce training regarding "how to access" the emergency medical services (EMS) system. It may also include additional hours of on-site medical team staffing.

**Contents**

This chapter contains the following topics:


| Topic |
|---|
| 3.1 Spectator, Workforce and Media Medical Care - Venues |
| 3.2 Spectator, Workforce and Media Medical Care - Outside Venues |
| 3.3 Additional Media Medical Care |

# 3.1 Spectator, Workforce and Media Medical Care - Venues

**Introduction**

Medical care will be provided to spectators, media, and the venue workforce at strategically located spectator medical stations, as well as by mobile teams that can respond to medical needs through the venue. The Spectator Medical Programme should also provide care to the Olympic Family members at the venue.

**Spectator Medical Stations**

The spectator medical station at each venue should provide first aid care, emergency response and stabilization of acutely ill or injured patients prior to transfer to the hospital, and may include limited primary care services.

### Access to Care

All individuals working at or visiting the venue should have access to the venue's spectator medical services. Given this broad access, it is important for the OCOG medical team to discourage or limit activities which could cause over-crowding and interfere with the delivery of medical care and patient privacy (i.e. individuals coming in to cool-off/warm-up, change diapers, breastfeed infants, etc.)

### Staffing

The station should be staffed by a physician and nurse and may include other support staff, as well. In addition to the provision of first aid and medical care, staff duties will include documentation of care; operational and clinical reporting; management of equipment and supplies; communication; and base of operations for the venue's mobile medical teams.

### Facility and Location

The facility and its location can vary depending on the venue design and capacity. The station may utilize existing indoor space, a tent, or other temporary structure such as a modular trailer. The main considerations are that the structure can be secured; temperature-controlled; and allow space for necessary services to be provided. The location of the facility should be based on proximity to the spectator areas and access by EMS vehicles. There must be adequate and effective signage so that the medical station is easily located. The space should allow for examination and treatment areas, a waiting area, toilet and hand-washing facilities; and workspace for the medical volunteers. Privacy should be addressed with walls, space, screens or curtains.

Continued on next page

# 3.1 Spectator, Workforce and Media Medical Care - Venues, Continued

**Mobile Medical Response**

Mobile medical response teams should be stationed strategically to allow for prompt response to all spectator and operations areas of the venues. Access may be limited in certain areas, such as the media compound, so the OCOG medical team should work closely with Venue Management and the OCOG's Accreditation functions.

### Supplies

The mobile responders should be equipped with those items they will need for the areas in which they are assigned. Supplies may include:

| | | | |
|---|---|---|---|
| CPR masks | Antacid tablets | Acetaminophen | Adhesive bandages |
| Exam gloves | Gauze pads | Emergency glucagons | Elastic bandage |
| Lip balm | Sunscreen lotion | Anti-infective ointment | Throat lozenges |

Equipment such as gurneys, wheelchairs, and AEDs (automatic external defibrillators) should be strategically located so they can be brought quickly to any location on the venue, if needed. Medical teams may also require access to golf carts, gators or snowmobiles to provide "intra-venue" transport in geographically large venues.

### Staffing Locations

Assignments for the mobile medical responders should effectively support spectator areas; media compounds; venue functional work areas; and Olympic Family seating and lounges. Because some venue areas have restricted access, the standby locations must be reviewed with venue operations and the accreditation manager who will ultimately approve access for the various medical responders throughout the venue. The medical planners should consider rotating the positions of staff, in the case of severe weather conditions.

### Communications

Depending on the location of the mobile responders, they may either be equipped with radios or cell phones, or they should have easy access to the telecommunications equipment that is located in their standby locations. In all cases, they should be able to call for additional medical response, if needed, and they should be easily accessible by phone or radio.

Continued on next page

# 3.1 Spectator, Workforce and Media Medical Care - Venues, Continued

**Mobile Medical Response** (Continued)

### Medical Emergencies

If an individual becomes seriously ill or injured, whether in the spectator areas or any operations area of the venue, all venue-based workforce should be trained to call the venue communications centre (VCC) immediately. The VCC will contact the venue medical officer (VMO) and the dispatch of medical response will be initiated according to pre-determined protocols. The medical first responders, in consultation with the VMO or his designee, will determine whether the patient should be assisted to the venue medical station or transported directly to the hospital.

**Emergency Medical Services (EMS)**

Generally, the Medical Services team should plan to staff two ambulances at each venue during operational hours. At competition venues, one ambulance can be dedicated to the athletes. This EMS coverage may be revised (increased/decreased) after detailed review of:

- Proximity to the nearest hospital
- Proximity to community-based EMS resources for back-fill
- The security process that will be required to inspect and secure the ambulance prior to entrance to the venue)

In some cases, air-ambulances) may be on-venue to meet competition requirements of certain high-risk sports. Unless the injury or illness of the spectator, OF, media or workforce is life-threatening, the venue should not dispatch the on-venue air-ambulance. Rather, the venue medical team should call for a community-based med-evac helicopter or transport the patient by ground, as directed by the VMO.

Communication and decision-making for EMS dispatch should be coordinated by the VMO or his/her designee. The EMS resources must be dispatched with discretion and kept available for true emergency transport needs. If non-emergency transport assistance is required, vehicles other than ambulances should be made available. When an on-site ambulance leaves the venue to transport a patient, there should be a plan for immediate dispatch of a back-fill unit. The venue communications centre (VCC) should be included in relevant communication regarding EMS dispatch to ensure other venue functions respond as needed (i.e. security, event services, etcetera). The community-based EMS dispatch centre should be notified so they can coordinate dispatch of back-up units.

The EMS team and/or its life-support equipment may be utilized as part of the venue mobile medical response team, however, since the EMS team may be required to transport a patient off the venue, the EMS staff and equipment cannot be the sole resource allocated for mobile medical response within the venue.

More information is listed in the Medical Transport section of this manual.

# 3.2 Spectator, Workforce, and Media Medical Care - Outside Venues

**Introduction**

Although the OCOG is not obligated to provide the medical care of spectators, media, and the workforce outside the venue, OCOG Medical Services should plan for the efficient and effective referral of such patients when they require further treatment than what can be offered at the venues.

Medical Services should identify and establish planning activities with those community-based medical facilities that would be most appropriate for patient referrals. This will create a better experience for the patients and help reduce delays and crowding at the community-based clinics and hospitals. Considerations include proximity to venues and accommodations, capacity, and specialization of these health care facilities.

**Pre-Games Planning**

Pre-Games planning should include:

- OCOG Medical Services should coordinate meetings with local clinics and hospitals
- OCOG Medical Services should explain the level of care at the venues
- Venue schedules/capacities should be shared with local providers
- Information about community-sponsored or private events should be reviewed
- Local providers should then determine hours of services during Games-time (they may consider extended hours of service)
- Hospitals and/or clinics should revise staffing schedules, if indicated
- OCOG Medical Services should capture all relevant information for the medical facilities that will to be utilized for Olympic-related referrals (clinic/hospital names, addresses, contacts (medical director/emergency room/front desk), phone numbers, travel directions from nearby venues, hours of service, etc.)

Continued on next page

# 3.2 Spectator, Workforce, and Media Medical Care - Outside Venues, Continued

**Non-Emergency Referrals**

During the Games operational period, the medical teams at the venues will be responsible for facilitating referrals. This may include some or all of the following activities:

- If initial medical care has been provided to the patient, a copy of the patient's chart and written referral note should be given to the patient
- Patient should be given clinic/hospital information (address, phone, directions)
- If patient will go immediately to the referral facility, venue medical team should call to notify facility
- If patient does not require definitive care immediately, the venue medical team may assist with scheduling an appointment or the patient should be instructed regarding how to schedule an appointment
- If patient will have any difficulty reaching the venue's departure shuttle stop or parking lot, the venue medical team should contact the venues' spectator services team for assistance, or a member of the medical team should assist the patient to their personal vehicle, taxi, or to mass transit. This may require a wheelchair, golf cart, gator, or snowmobile.

The Venue Medical Officer, in consultation with his/her venue medical team, will determine when such a referral should be reported to the venue communication centre (VCC) and/or the OCOG's medical headquarters (MHQ).

**Self-referring Olympic-related Patients**

Area hospitals and clinics (even if not designated as an Olympic Hospital) should be instructed to notify the public health department and the OCOG's MHQ, if they become aware of significant illnesses or injuries that have occurred at an Olympic venue. If a community-based clinic or hospital treats or admits a member of the Olympic Family, they should notify MHQ. When the patient has been stabilized, MHQ can then make arrangements to transfer the patient to an Olympic hospital, if appropriate.

# 3.3 Additional Media Medical Care

**Introduction**

Leading up to and during the Games period, there will be thousands of press and broadcast media in and around the host city. Many of the accredited media will be working at the OCOG's IBC (International Broadcast Centre) and MPC (Main Media Centre), at the venues, and in the community at large. Many of the media will coordinate with the OCOG's Accommodations Function to find appropriate housing – sometimes set-up as Media Villages.

The media are often working around-the-clock and these long work hours may compromise their health. During this busy work period, the OCOG should plan to provide a medical station at the IBC/MPC (or at the combined Main Media Centre, MMC). If the OCOG is providing a media village, Medical Services should also be asked to provide limited first aid services at the media village.

**International Broadcast Centre (IBC), Main Press Centre (MPC), Main Media Centre (MMC)**

The medical station(s) at the IBC and MPC (or combined MMC), should be set-up with the same considerations as the spectator medical stations. The medical station should be located in a quiet part of the building, if practicable. If space permits, it is recommended to provide several cots for the media to rest when they are feeling ill.

### Access

The medical team should plan to provide services to the media and to the OCOG workforce in the media centre(s).

### Operational Period

The operational period of service should cover the official operating days at the media centre(s) and the medical station should be staffed 24 hours a day. The operating period of the media centre may begin before the opening of the Olympic Village. In this case, the OCOG may either extend the required period of medical operations to support coverage of the early operational days of the media centre(s), or they may refer early arriving media to community-based health facilities.

Continued on next page

# 3.3 Additional Media Medical Care, Continued

**International Broadcast Centre (IBC), Main Press Centre (MPC), Main Media Centre (MMC)** (continued)

### Staffing

The medical station should be staffed with a physician and nurses. It is not necessary to staff a physician during the entire 24-hour period; however, on-call physician coverage and scheduled physician hours are required. The medical staffing plan should ramp-up as the presence of the media grows so the number of medical staff will be relative to the number of media.

### Emergency Response (EMS)

The requirement for on-site ambulances during the Games period will be determined based on proximity of the media centres to the hospital; security measures implemented in the media centres; and the operational dates and hours of the media centres. Whether EMS is on-site or responding from the community:

- There should be basic life support equipment that can be brought to any location in the media centre
- In such life-threatening situations, transport to hospital for definitive care must NOT be delayed in favour of on-site treatment
- If the patient is not in a life-threatening situation but needs transport assistance to the medical station, there should be transport equipment available, such as a wheelchair and/or stretcher

**Media Villages**

Because the Accommodation Programmes for the media vary in host cities, there are no specific requirements for a Media Village Medical Programme. The OCOG should review accommodations plans, keeping in mind the overall goal of providing an effective Health Programme for the media while they are in the host city. A possible solution may include establishing a small first aid station staffed with nurses with scheduled physician visits during certain periods of the day or evening.

Whether there is a Media Village Medical Programme or not, it is important to educate the media regarding how to access medical care at the venues, media centre(s), and in the community.

# 4.0 → Medical Care - Olympic Family

## Executive Summary

**Introduction**

This chapter describes medical care in relation to the Olympic Family.

**Overview**

In referencing Olympic Family (OF) for this chapter, the term OF will generally include members and staff of the IOC; heads of state and other dignitaries; secretaries general, officials, and staff of the International Federations and National Olympic Committees; and designated guests of these groups. Please note: athletes are members of the Olympic Family but have been addressed separately in this manual. Medical Services should work with the OCOG's Accreditation function and the IOC to review this definition.

Developing a comprehensive OF Medical Programme provides numerous benefits:

- Helps the accredited international guests access medical care efficiently, minimizing interruption to the OF members' official duties
- Identities medical facilities and resources in advance so special preparations can be made to minimize the impact of increased demands during the Games-time period

OCOG Medical Services should provide facilitated access to care for OF members and ensure effective continuity of care for these patients should they be treated at multiple facilities or require multiple visits.

**Communication Regarding OF Members Medical Status**

The OCOG should respect confidentiality of all patients in their care. Only with the OF member's permission should the OCOG medical staff consult with and/or update the delegation regarding medical care provided to the OF member.

In the case of significant illness or injury of an OF member, the VMO in consultation with the OCOG's Chief Medical Officer may determine that the OCOG main operations centre (MOC) should be notified.

Continued on next page

# Executive Summary, Continued

**Communication Regarding OF Members Medical Status** (Continued)

This notification should protect confidentiality issues, but if a medical situation occurs that is likely going to get media attention or require notification of the OF member's delegation, the MOC should be informed.

The IOC Medical Director/IPC Medical & Scientific Director will also need to be kept informed about significant illness or injury of OF members.

In addition to these "real-time" notification protocols, OCOG medical services will need to prepare after-action reports summarizing medical care provided to the OF members and to other constituent groups. See section on Medical Publication, Forms, and Reporting later in this manual.

**Contents**

This chapter contains the following topics:


| Topic |
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| 4.1 OF Medical Care - Venues |
| 4.2 OF Medical Care - OF Hotel and Polyclinic |
| 4.3 OF Medical Care - Outside of the Venues, including Olympic Hospital |

# 4.1 OF Medical Care - Venues

**Introduction**

Members of the Olympic Family may be at the venues in a working capacity or they may be attending the event as spectator. In carrying out official duties, the OF member may have access to any zone relevant to their official responsibilities. As an honoured spectator, the OF will have access to a restricted seating area and to the Olympic Family Lounge located at each venue. The venue's spectator medical services shall provide for the needs of the Olympic Family, should they become ill or injured at the venue.

**Accessing Venue Medical Services**

The OCOG's Olympic Family Services function will have assigned volunteer OF Assistants in the OF seating areas and OF lounges during events. These assistants should know exactly where the spectator medical station is located and know how to contact the medical staff assigned there. If an OF member becomes seriously ill or injured, the OF Assistants should be trained to call the venue communications centre (VCC) immediately. The VCC will contact the venue medical officer (VMO) and the dispatch of medical response will be initiated according to pre-determined protocols.

### OF Seating and OF Lounges

The VMO, together with venue management, will decide prior to Games-time, whether it is necessary to assign medical staff directly within the OF seating area and/or the Olympic Family Lounges, or if mobile medical responders that are stationed nearby these areas will be able to respond if and when needed. Usually, nearby responders will be adequate. The OF seating areas and OF Lounges should be reviewed prior to Games-time to determine is there is a "semi-private" place that a patient could be evaluated and also to plan the best routes for medical responders or patient transport (to spectator medical station or to ambulance).

### Mobile Medical Response

If an Olympic Family member requires non-acute mobile medical response (i.e. first aid), the spectator medical station doctor or nurse may send a mobile medical responder to evaluate or provide services or they may suggest that the OF member be seen at the spectator medical station.

Continued on next page

# 4.1 OF Medical Care - Venues, Continued

**Accessing Venue Medical Services** (continued)

If it is decided that the OF member should be seen at the spectator medical station, the doctor or nurse doing the telephone triage should determine whether an OF Assistant can accompany the patient to the Spectator Medical Station or whether a Mobile Medical Responder should be dispatched to assist the patient.

### Spectator Medical Station Services

First aid and limited primary care services will be available in the Spectator Medical Station (see section on Spectator, Media, and Workforce Medical Care). The special consideration in treating OF members is the provision for effective case management in the event the patient is transferred elsewhere for definitive or follow-up care. If care provided at the venue is minor and the patient is discharged without recommended follow-up care, no additional steps are required.

**Medical Case Management for OF Members**

If an OF member is transferred to another OCOG medical facility for definitive, diagnostic, or follow-up care, the VMO or his/her designee is responsible for making arrangements including as described in the following table:

| Action | Purpose/Comment |
|---|---|
| Determining the best OCOG medical facility | To provide the definitive or follow-up care (IOC Hotel medical service, Olympic hospital, village polyclinic) |
| Calling the referral facility | To notify them of the referral and to give relevant clinical history |
| Sending a copy of the patient's chart | Send to the referral facility (this may be faxed directly or by sending a copy can be sent with the patient) |
| Making transport arrangements | The VMO or his/her designee will determine whether ambulance transport is required, in accordance with medical indications and standards of care. Many OF members will have access to T-1 or T-2 cars and drivers. In non-emergency cases, the OF member may be driven to the referral facility in these vehicles. |
| Notifying the OCOG's medical headquarters (MHQ) | Case management can be initiated. MHQ must have protocols for when to notify the Chief Medical Officer (CMO) and OCOG's main operations centre (MOC). |
| Notification of the OF member's delegation (with permission of the patient) | The treating physician should make this call, if possible. |

Continued on next page

# 4.1 OF Medical Care - Venues, Continued

**Medical Staff Access to Restricted OF Zones**

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There is a particular challenge with regard to determining appropriate venue zone access for medical responders. The zone access notated on the staff Accreditation Badge is a credential that allows the workforce access to those areas in which he/she will do their work.

The Venue Management, Event Services, and Security functions develop overall venue operations plans and determine access criteria for restricted areas of the venue. The operations plans will have a provision for routine circumstances and they will have special provisions for emergency situations or special circumstances. The medical responders may need access to restricted areas in an emergency, but also in non-emergency circumstances. Venues will not assign more access than the medical responders would *generally* require doing their jobs. A possible solution is to have special access passes that can be given on a day-to-day basis to just those medical responders that are assigned in close proximity to restricted OF areas. In no circumstances should there be undue delay of the medical responders at the entry point to the restricted area.

Please see Accreditation and Entries at the Olympic Games – User's Guide for more information.

# 4.2 OF Medical Care - IOC Hotel and Polyclinic

**Introduction**

Providing medical care at the IOC Hotel supports those OF members whose official obligations keep them from easily accessing services at the venues or in the community. Allowing referrals to the Village polyclinic may benefit not only the OF member, but also those responsible for their care because it may be easier to provide services within the controls of the OCOG Medical Programme than to coordinate with community-based medical facilities.

In some instances, it may be more appropriate to refer OF members directly to Olympic Hospitals. This is addressed in the following section, on page 92.

**IOC Hotel Medical Services**

### Scope of Services

The services at the IOC Hotel should include first aid, limited primary care, and initial response for acute illness or injury. Depending on the location of the IOC Hotel and the security implemented at the hotel, a dedicated on-site ambulance may be recommended. The medical station should be equipped in a similar fashion to the venue Spectator Medical Stations, but on a smaller scale. There should be a plan to fill prescriptions for OF members. This can be accomplished at the Polyclinic pharmacy or by a nearby community-based pharmacy. Either way, OCOG Medical Service must plan for prescriptions to be delivered or the prescriptions must be filled at no charge to the OF members.

### Accessing Care

The IOC Hotel medical station should be covered 24 hours a day by nursing staff with scheduled hours of physician coverage. The OF member may come to visit the medical station, or they may request that the doctor visit them in their room. Consideration of such requests for room visits should be based on the nature of the complaint and the ability to conduct an effective assessment of the patient in that setting. Medical Services should work with OCOG Accommodations or Olympic Family Services to request a sleeping room so that a doctor can be on-site to respond during the night-time shift.

Continued on next page

# 4.2 OF Medical Care - IOC Hotel and Polyclinic, Continued

**IOC Hotel Medical Services**

▶ IPC

### Dates of Service

The IOC Hotel medical station should be staffed during the official operational period of the IOC Hotel, which is typically 10 days to 2 weeks prior to the Opening Ceremony through 1-3 days after the Closing Ceremony. If there are any early arrivals of OF members, Olympic Family Services should be instructed to notify the Chief Medical Officer (CMO) or the OCOG's medical headquarters (MHQ).

### Paralympic (IPC) Hotel Medical Services

Due to the smaller scale of operations and smaller size of the delegations, the IPC Hotel may or may not require a staffed medical station. This need for on-site medical care at the IPC Hotel should be reviewed with Paralympic Family Services and the Medical Director & Scientific of the IPC.

**Polyclinic Services for OF Members**

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The Village polyclinic will have specialty medical services including medicine, orthopedics, radiology, and emergency ophthalmology and dental care services. The OCOG's venue medical officers (VMOs) must be well aware of the scope or services available at the polyclinic and when referral to the polyclinic is appropriate. The polyclinic is provided for the care of the athletes, so resources will be prioritised for the athletes over OF members. Acutely ill OF members should always be referred to an Olympic Hospital.

### Access to the Olympic Village

Access to the Village is restricted and many OF members will not have access to the residential zone of the Village on their accreditation badge. This means the referring venue medical team should make arrangements for a day pass. Day passes have to be requested the day prior to visit, so if the OF member must be seen immediately for definitive care or diagnostic services, they should be referred to an Olympic hospital.

More information can be found in the Accreditation and Entries at the Olympic Games – User's Guide and the Technical Manual on Olympic Village.

# 4.3 OF Medical Care - Outside Venues, including Olympic Hospitals

**Introduction**

Other than in acute medical emergencies occurring outside of an Olympic venue, OF Members are requested to always be assessed by an OCOG medical staff member prior to seeking care at community-based medical facilities. This allows for better case management and also makes it easier to manage medical costs covered by the OCOG.

In medical emergencies occurring outside an Olympic venue, individuals will access the host city's emergency response system. For this reason, it is important that OCOG Medical Services and the community-based EMS system have pre-determined protocols to identify OF members, direct admissions to Olympic hospitals when practicable, and notify the OCOG's medical headquarters (MHQ) of the treatment and disposition of OF members.

**Olympic Hospital**

OF members may require care that cannot be provided at the venue medical stations, IOC Hotel or the Village polyclinic. For such circumstances, the OCOG should have identified and duly prepared, a system of Olympic hospitals. Advanced preparations will include planning for security; language services; privacy from the media; facilitated admission and billing procedures and communication with the OCOG's MHQ and/or venue medical officers (VMO) from the referring venue. Olympic hospitals are described in section 2.4 of this manual.

**OF Members Accessing Medical Care Outside of the OCOG Medical Programme**

OF members are asked not to self-refer to community-based healthcare facilities without prior assessment by the OCOG medical staff. If an OF members becomes ill or injured and is not in close proximity to an OCOG medical facility, they should notify the healthcare facility (and ambulance team if EMS was involved) of their OF status. The healthcare facility should then notify the OCOG's MHQ. This is why it is important for the OCOG Medical Services team to have met with all health care facilities in the area and provided information to them regarding how to contact the OCOG's MHQ during the Games-time period.

Continued on next page

# 4.3 OF Medical Care - Outside Venues, including Olympic Hospitals, Continued

**OF Members Seeking Elective Care**

The OCOG Medical Programme provides only for the care of acute and emergent illness or injuries that arise during the Games-timer period. If OF members desire to access the host city medical system for "non-covered" elective care, this is their prerogative and OCOG Medical Services is not responsible for such care. The OCOG medical team may, however, offer referrals to the most appropriate providers or facilities if the OF members seek such recommendations.

# 5.0 → Medical Transport

## Executive Summary

**Introduction**

This chapter describes the transport aspects as related to Medical Services.

**Overview**

Medical transport planning requires effective integration and cooperation between many OCOG functions and community-based agencies. Factors that add complexity to this planning include:

- Limited EMS resources (med-evac helicopters, ground ambulances, EMS staff)
- Increased security impacting ambulance and EMS staff access at venues
- Increased traffic and/or travel restrictions that could impact existing EMS routes
- Increased security of air space
- Increased media presence and high-profile events and participants
- International visitors that are unfamiliar with the local health care system
- Language and cultural barriers and considerations
- Capacity and integration issues impacting communication systems

The operational procedures involved in activation of EMS should be developed and agreed upon by OCOG Medical Services and community-based EMS management. It is important for the community-based EMS system to understand the access-control issues associated with an Olympic Games and it is equally important for the OCOG to recognize and respect the safe operational procedures that have been developed from the expert experience of the EMS programme. In responding to athlete injuries, EMS must allow the OCOG medical team to respond and assess an injured athlete prior to activation of EMS response.

More information can be found in the Technical Manual on Transport.

**Contents**

This chapter contains the following topics:


| Topic |
|---|
| 5.1 Ambulance - Ground |
| 5.2 Ambulance - Air |
| 5.3 Non-emergency Medical Transport |

# 5.1 Ambulance - Ground

**Allocation of Resources and Operational Consideration**

Generally, Medical Services should plan to staff two ambulances at most venues, one for athletes and one for spectators. This EMS coverage may be revised (increased or decreased) after detailed review of:

- Risks inherent to the sport or non-competition event
- Proximity to nearest hospital and/or nearest Olympic Family Hospital
- Proximity to community-based EMS resources for back-fill
- Security process that will be required to secure and inspect the ambulance prior to entrance to the venue

The communication and decision-making for dispatch, response, and transport of patients by EMS must be coordinated by the venue medical officer (VMO) or his/her designee. The EMS resources should be dispatched from the venue with discretion and kept available for true emergency transport needs. If non-emergency transport assistance is required, vehicles other than ambulances should be available. When an on-site ambulance leaves the venue to transport a patient, there must be a plan for immediate dispatch of a back-fill unit.

**EMS Vehicles**

Ideally, advanced life support (ALS) ambulances should be assigned to the venues. Minimally, at least one of the two ambulanced assigned to a venue should have ALS capabilities. When the OCOG and EMS agencies plan to assign EMS resources for multiple events, they should consider that schedules at the venues overlap and outdoor events may be delayed or rescheduled on subsequent days. Since ambulance resources are limited in most communities, the EMS system is encouraged to seek short-term solutions to access additional units. This may include mutual-aid agreements with nearby communities or loaner-units accessed from ambulance manufacturers. The planning for these resources must be initiated far in advance of the Games

For intra-venue transport, multi-terrain gators, golf carts, or snowmobiles may be a good complement to ambulances. These should be adapted or equipped to support safe patient transport.

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# 5.1 Ambulance - Ground, Continued

**EMS Staffing**

EMS systems and staff qualifications vary among host cities, so EMS staffing plans will also vary. EMS must be able to provide advanced life support and this can be accomplished with the appropriate complement of emergency medical technicians, volunteers, doctors, nurses and/or paramedics.

EMS staff may be volunteers or paid contractors from the EMS agencies in the venue cities. Utilizing EMS staff that are familiar with the transport routes, communication protocols, and operational procedures is strongly recommended.

In building additional EMS capacity for the Games-period, it is important that EMS staff that may not be "local" have the opportunity to become familiar the transport routes, communication protocols, and operational procedures. This means if EMS staff is going to be recruited from outside the area, the recruitment and selection should occur with plenty of time to fully train such EMS staff prior to the Games period.

**Staging Locations**

During the design phase of the venue, the standby location of the ambulances must be established. Considerations for appropriate location include spectator flow; access to the Field of Play, Athlete Medical Station, Spectator Medical Station; and egress from the venue. For winter Games, the ambulances may need heated shelters (or access to electrical outlets for block heaters and protection from snow and ice).

**Vehicle & Staff Accreditation or Passes**

The dedicated vehicles and staff scheduled for the event may be dispatched for patient transport outside of the venue, so EMS and the OCOG's Accreditation, Security and Transport functions should pre-determine the best method to allow back-fill ambulances to access the venue expediently. This may be accomplished by pre-identifying all legitimate EMS vehicles with a pass or signage and accrediting all EMS staff that could potentially be scheduled to respond as a back-up unit to a venue during Games-time. Security procedures, i.e. "sanitization" of the vehicle, must be enforced to ensure venue safety, but should be expedited.

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# 5.1 Ambulance - Ground, Continued

**EMS Routes**

The EMS agencies should work closely with the OCOG's Transport function and the host city's transport and law enforcement planners. During Games-time, certain roads may become closed to all traffic, or restricted to certain vehicles, which could impact existing EMS routes. Event schedules and traffic volumes should be reviewed and EMS routes revised, if necessary. If planned EMS routes are altered, the EMS agencies are responsible for adequately training all EMS drivers regarding Games-time routes.

**In-venue EMS Response Protocols**

EMS teams should be included in developing intra-venue response protocols and must participate in venue-based pre-Games training. Response protocols should meet the local EMS agency's recognized standards of care but should be adapted for the unique circumstances of the Olympics. This means recognizing the VMO as an authority and ensuring a collaborative approach between the VMO and the community-based medical control for the EMS responders.

**Communication**

Effective communication between venue medical services, venue EMS, OCOG Medical Headquarters (MHQ), and the EMS dispatch centre should be ensured. A good principle is to utilize existing communication protocols and only adapt them only as necessary.

Radio and cellular communication channels should be reviewed to ensure adequate capacity for the increased demand during Games-time. The EMS agencies will need to communicate planning initiatives with the OCOG's Telecommunication function, which can be facilitated by OCOG Medical Services.

### Importance of Understanding Communication Structure

The EMS agencies should understand the OCOG's communication structure. The OCOG will implement venue communication centres (VCCs) and a central command or main operations centre (MOC). OCOG Medical Services, including venue-based medical teams and the MHQ, should communicate with the OCOG through these structures as well as with the community-based health agencies.

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# 5.1 Ambulance - Ground, Continued

**Communication** (continued)

### Intra-venue Communication Considerations

The OCOG Medical Team should consider the following:

- Response for athlete: FOP medical responders will respond and evaluate athletes when there is an accident during competition or training. Each venue medical team should determine the best method to activate EMS response to the FOP. The VCC should be aware of any activation of EMS so they can alert other relevant functions such as security at the egress control point.
- Response for spectators, workforce, Olympic Family, media, etc.: Calls for medical response should go to the VCC, which may have a dedicated medical dispatcher for triaging the calls or the calls may be routed to the VMO or his designee. The medical dispatcher or VMO/VMO designee will determine if the OCOG mobile medical teams or EMS (or both) should respond to the scene.
- EMS staff should be easily accessed by the VCC and medical staff. The communications equipment (radio or cellular phone) can be determined locally.
- EMS staff should be able to communicate with their community-based EMS dispatch and with the venue medical team.

### EMS Dispatch Centres

The dispatch centres should stay in communication with the EMS staff assigned to venues and with the OCOG Medical Headquarters (MHQ). Communication with the OCOG should include:

- Report regarding disposition of patient transported from Olympic venue
- Transport (or request for transport) of an OF member from non-Olympic venue
- Hospital capacity problems (diverting patients due to over-crowded emergency rooms, etc.)
- EMS transport route status which could impact response to or transports from venue
- Mass casualty situations that could potentially impact OCOG-dedicated EMS resources
- EMS staff sick-calls or other staffing changes

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# 5.1 Ambulance - Ground, Continued

**Air Ambulance Resources**

In some cases, air-ambulances (i.e. med-evac helicopters) may be dedicated to a venue to meet the competition requirements of certain high-risk sports. These requirements may be defined by the International Federations of Sport (IFs). In most cases, air-ambulance will respond from strategically positioned standby locations outside the venue.

EMS and HEMS (helicopter EMS) agencies should have access to Games-time competition and event schedules as soon as they are available, so they can anticipate likely activity levels assess capacity requirements for Games-time. Event schedule changes should be shared with EMS/HEMS as soon as available.

**Control of Air Space**

During the Games-time period there may be additional control of air space to accommodate special security measures and increased helicopter activity. It is important that all planners (law enforcement, military, OCOG security, airport air-traffic control, etc.) recognize the priority of HEMS and develop protocols that do not interfere with HEMS response to the venues. The OCOG's Security function should be well briefed on standard HEMS response protocols and support the HEMS representatives in planning initiatives.

**Venue Landing Zones**

As the venues are being designed, it is very important to pre-identify landing zones at all venues that may require HEMS response. The landing zones must be maintained during venue operational hours to avoid the delays associated with clearing and securing the landing zones. In some instances the landing zone may be some distance from the field of play (FOP). If such is the case, ground ambulances (or snowmobiles, carts or gators adapted for patient transport) should be available to transport the patient to the landing zone.

The FOPs should be designed to allow for evacuation of an injured patient without the need for helicopter hoist operations, which put not only the athletes, but also the flight crew at risk.

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# 5.1 Ambulance - Ground, Continued

**Venue Response Communication**

The HEMS crew should be able to respond through the community-based EMS dispatch structure. This require relay of patient status from the venue medical response team to the EMS dispatch team.

The HEMS crews should be briefed on any modification of standard air-traffic control procedures for approach to the venues. If landing zone procedures can be conducted with signals, direct communication with the venue team may not be required. If direct communication is required, the OCOG medical team may be able to be patched in through the EMS communication system. If the OCOG is considering issuing venue-based radios to the helicopters, they should determine if all of the venues will be set up on a standard radio system or if the communication systems will be localized since HEMS resources may respond to more than one venue.

# 5.2 Non-Emergency Medical Transport

**Introduction**

OCOG Medical Services should be able to provide transport assistance to individuals being referred for medical care within the Olympic system. In helping individuals access the appropriate medical resources, the use of EMS (emergency medical services, i.e. ambulances) should be limited by medical need as determined by local standards of care. For non-emergency transport of accredited individuals, OCOG Medical Services can facilitate this transport using OCOG vehicles. For non-accredited individuals, limited assistance may be required if such persons are present at an Olympic venue and need help leaving the venue.

**Athlete – From Venue**

When the venue-based medical team determines that definitive care is best provided through other medical resources, they must decide if the athletes should be referred to their own NOC team doctors, to the polyclinic, or to an Olympic Hospital. Once it is determined that the athlete does not require EMS transport, there are several options:

- The athlete can stay with the team and travel back to the Village on the NOC bus
- The NOC will have an OCOG-issued car, so the athlete and another member of the NOC may have access to that vehicle
- Medical Services can call Venue Transport and request a car and driver from the venue-based car pool
- Medical Services can call Venue Transport and request a T-3 car and driver

Once the transport vehicle has been arranged, Medical Services should make sure the athlete and his/her representative from the NOC has the phone number, location, and driving instructions for the referral facility. Medical Services should call the referral facility to notify them of the referral.

If the athlete is being referred to the polyclinic, the driver should be made aware of village access procedures at the village transport plaza. If the athlete has any difficulties with ambulation, the polyclinic staff should be asked to meet the athlete at the village access point to assist with “intra-village” transport to the polyclinic.

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# 5.2 Non-Emergency Medical Transport, Continued

**Athlete – From Polyclinic**

If an athlete is assessed at the polyclinic and it is determined he/she needs additional treatment or diagnostic services that cannot be provided at the polyclinic, the athlete may be referred to the Olympic Hospital or to a pre-identified ambulatory clinic that has been set-up as a referral site. The polyclinic staff should be sure they have access to an OCOG vehicle at the village. If the NOC prefers, they can use their NOC assigned car. In many instances, it may be appropriate for the polyclinic to send an OCOG medical volunteer with the athlete.

**Olympic Family**

Referral of an OF member should be handled in much the same way as an athlete. In most cases, the OF members will have access to a "T-1" or "T-3" vehicle and driver. T-1 status means the OF member has their own dedicated care and driver. T-3 means the OF member has access to the T-2 pool of cars and drivers. The T-3 cars should be arranged through the transport desks at the venues or the IOC Hotel.
See chapter on OF Medical Care in this manual for information about day passes for the polyclinic.

**Workforce & Media**

Most workforce and media will have used OCOG transport to get to the venue since the OCOG often provides a shuttle system from an off-site parking area or from the media centre(s). If a workforce member or a member of the media become injured or ill at the venue, and definitive care cannot be provided at the venue medical station, OCOG Medical Services should make help assess the options for transport. The individual may be able to use the OCOG shuttle system. If this is not a good solution, the venue transport desk may be consulted to see if a car and driver is available.

In addition to arranging transport, Medical Services should have provided the individual with referral information (i.e. location and phone number for the referral facility, driving directions, etc.)

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# 5.2 Non-Emergency Medical Transport, Continued

**Spectators & Others**

In the instance that spectators or other non-accredited individuals that are discharged from venue medical stations may need assistance to depart the venue, the OCOG should provide assistance by way of wheelchair, golf cart, snowmobile, car and driver or taxi service to a transport hub, park and ride facility or to their residence.

# 6.0 → Relationship with Public Health Authorities

## Executive Summary

**Introduction**

This chapter describes the relations between the OCOG Medical Services Function and the Public Health Authorities

**Overview**

In order to provide the healthiest experience for the Games participants and the residents of the host country during the Games-period, the OCOG's Health and Medical Programme should be integrated with existing or enhanced public health initiatives and controls. Members of the IOC, IPC, NOCs, IFs, sponsors, media, spectators, workforce and other Olympic- and Paralympic-related organisations will look to OCOG Medical Services for guidance in complying with such initiatives and controls.

Medical Services has a responsibility to educate the participants of the Games regarding health regulations and facilitate their compliance. The OCOG also has responsibility to act as liaison to the public health agencies to provide relevant information about the Olympic programme and its participants.

**Contents**

This chapter contains the following topics:

| Topic |
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| 6.1 Control of Air, Water, & Food Supplies |
| 6.2 Public Health Surveillance |
| 6.3 Health Regulations & Entry Rules |
| 6.4 Health Promotion |

**Service Delivery Agreement** △

An appropriate signed agreement with relevant public agencies must be completed to assure proper delivery of services from Host City and country authorities.

# 6.1 Control of Air, Water & Food Supplies

**Introduction**

During the Olympic period, there are increased risks placed on the air, water and food supplies in the venue cities. Some of the risks are based on capacity and the number of visitors and workforce present for the Games, and some are risks associated with mischief or terrorism-related activities.

OCOG Medical Services will act as a liaison to the local health agencies to facilitate planning for effective controls. In addition, numerous local and national authorities involved in control of air, water, and food supplies will work with many other OCOG functions including Food & Beverage, Venue Development, Security, Venue Managers, and many contractors involved in providing services to Olympic visitors.

**Air Safety**

The risk of air pollution is increased during Games-time by exhaust from Games-time shuttle busses and cars, heating/cooling systems in temporary facilities, etc.
In addition to air pollution, crowding can increase the risk of spreading communicable illnesses. The venue cities should also consider the risk of exposure to biological or chemical agents resulting either from natural or purposeful events.

The responsible agencies should implement policies to mitigate air pollution; implement air monitoring technologies; and ensure effective response protocols to ensure the safety of the population.

**Water Safety**

The risk to water supply is increased during Games-time by the influx of visitors requiring more sanitary facilities, as well as the risk of exposure to biological or chemical agents resulting either from natural or purposeful events.

### Safety

The responsible agencies should implement policies to mitigate water pollution; implement water monitoring technologies; and ensure effective response protocols to ensure the safety of the population.

### Potable water

The OCOG should ensure access to potable water at the venues, in adequate quantities to address good hydration for those at the venues. Potable water should be available at no cost.

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# 6.1 Control of Air, Water & Food Supplies, Continued

**Water Safety** (Continued)

### Clean Water for Sanitary Use

The OCOG should also ensure adequate access to water at the venues for sanitary purposes. Alternatives such as waterless hand sanitizers at the temporary bathroom facilities are acceptable, but in food preparation and medical facilities, hand-washing facilities should be made available.

### Disposal of Waste Water

Venues may be located away from city sewer systems so the OCOG should make arrangements to dispose of wastewater without harm to the environment. In addition to the venues, provisions for proper disposal of wastewater should be implemented for community-sponsored events and service providers operating outside of the venues. The increased need for sanitary facilities (portable toilets) and collection of waste water from food preparation and other activities should be addressed early in the planning period so that resources can be brought in from outside the venue cities, if needed.

Due to the increased number of sites where temporary sanitary facilities will be located, the local agency's sanitary inspectors will be challenged to keep up with adequate inspection schedules. These agencies should make arrangements to augment the number of inspectors available during the Games-period.

**Food Safety**

Food safety is a serious concern during Games-time. Risks are associated with food preparation and also with the supply channel. Food vendors will include those contracted by the OCOG, but also includes food vendors who may wish to set up temporary restaurants or snack bars in the venue cities. Existing restaurants may have difficulty maintaining safe practices when they encounter the influx of Olympic participants.

### Prevention and Inspection

This increase of food preparation facilities puts a great burden on the local public health's food inspection system. Pro-active training of food handlers and heightened pre-Games inspections of food preparation facilities are required. In addition, the local public health food inspection teams should make arrangements to augment the number of inspectors available during the Games-period.

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# 6.1 Control of Air, Water & Food Supplies, Continued

**Food Safety**
(Continued)

### Food Vendor Licensing

The public health agencies should be made aware of the incidence of unlicensed food vendors that have attempted to set up food vending at past Games. If the venue cities determine that temporary food vending sites will be required to meet the demand, they should implement registration or licensing activities that will ensure adequate training and implementation of food safety practices. The OCOG's Food & Beverage Sub Function should be aware of such requirements in good time to implement optimal food safety practices in the OCOG food programme.

### Food Supply Chain Monitoring

Due to the high-volume and high profile of the Games, food supply channels may be at increased risk. Public health authorities should work with local law enforcement and security agencies to ensure safety of the food supply. The OCOG's contracted food vendors can review their food sources with these agencies to ensure optimal safety of food being brought into the village and venues.

# 6.2 Public Health Surveillance

**Introduction**

During Games-time there is an increased risk of communicable illness due to the influx of international visitors to the venue cities. Food-borne pathogens, exposure to biological or chemical agents, and cold- or heat- related illnesses should also be monitored for. Early identification of sentinel events will help prevent widespread exposures and minimize the impact on the community and visitors.

**Surveillance at Venues and Village**

During the planning phase, OCOG Medical Services should consult with public health experts to determine those symptoms that should be monitored at the venue medical stations and Village polyclinic. The OCOG's medical documentation system should be able to collect this data and Medical Services should implement a reporting system to provide this data to the public health authorities. Symptoms that should be monitored should include incidents of illness, exposure, and injury.

The OCOG's Chief Medical Officer (CMO) should appoint a "Health and Hygiene Officer" who will be based at the Village polyclinic, as noted in section 2.2.1 Polyclinic in this manual. This individual should oversee data collection, data sharing and data analysis for the OCOG's Medical Programme and will be the key contact for working with the public health authorities involved in surveillance.

**Tracking System** △

The OCOG must implement a computerised medical encounter tracking system to support public health surveillance during Games-time and to provide summarised data related to medical care provided during the Games period.

**Surveillance in Community**

Prior to Games-time, the public health agencies should establish benchmark thresholds for typical (non-epidemic) levels of illness in the area, so that deviations from the baseline can be easily recognized and responded to. Public health agencies may choose to heighten their existing public health surveillance in the community during Games-time and for a period of time following the Games. Existing regulations for reportable injuries and illnesses may be expanded to cover increased risk associated with visitors from foreign countries, prolonged exposure to high-risk weather conditions, and an increased number of food vending establishments, to name some examples. Data analysis should include existing community-based surveillance and the data being reported from the OCOG Medical Programme.

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# 6.2 Public Health Surveillance, Continued

**Collaboration & Communication**

Communication systems, including pre-scheduled conference calls, data reporting, data analysis, and communication protocols for emergency situations should be established and tested well before Games-time.

Public health agencies for the venue cities and at the national level should work in close contact with the OCOG, who will facilitate communication with the Olympic delegations, as necessary. The key contact should be either the OCOG's CMO or the OCOG's health and hygiene officer stationed at the Village polyclinic. The CMO should determine the appropriate communication of relevant data to be forwarded to the OCOG's main operations centre (MOC), to the venue-based medical teams, and/or to the NOC medical staff.

The IOC Medical Commission/IPC Medical & Scientific Department will ask for reports identifying suspected health problems, the status of known community health issues, and response initiatives.

Because some health threats could be tied to terrorist activity, the relevant law enforcement agencies will also be involved in the surveillance programme. IOC and OCOG medical representatives must be respectful of necessary restrictions on the information shared in the event of security risks.

# 6.3 Health Regulations & Entry Rules

**Introduction**

The OCOG should work closely with the venue cities, regional and national governmental agencies to identify relevant controls and recommendations regarding health and health-related entry rules. This section includes information on:

- Immunization and health status of those entering the country
- Importation of pharmaceuticals and other medical supplies
- Quarantine issues for horses involved in equestrian events

**Required & Recommended Immunisations**

The local and/or national health authorities should be able to provide OCOG Medical Services with information regarding required and recommended immunisations for athletes and other international visitors, and for the workforce. The World Health organisation (WHO) can be consulted for additional recommendations.

OCOG Medical Services should document these guidelines for required and recommended immunisations and share this information with:

- OCOG's Human Resources and Volunteer Services (i.e. regarding flu shots)
- Relevant functional managers (i.e. the Food & Beverage function - regarding food handlers' immunisation against hepatitis)
- NOCs, IOC, and Media organisations
- International guests and spectators
- Sponsors and licensees that will be sending representatives to the Games

The OCOG's NOC Services, Media Services (broadcast and press), Ticketing, and Olympic Family Services functions should be able to help disseminate relevant information to their respective constituencies. The constituent groups should also be encouraged to contact the WHO for additional information.

**Health Status**

During the Olympic Games, the Host Country can expect visitors from nations that may not typically send visitors. Immigration authorities and pubic health officials should be able to provide information to OCOG Medical Services regarding health status parameters that could restrict persons from entering the country. OCOG Medical Services should document relevant health status restrictions and ensure that the relevant constituent groups are made aware of them, as noted above.

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# 6.3 Health Regulations & Entry Rules, Continued

**Importation of Pharmaceuticals and other Medical Supplies**

Most host country's immigration and customs agencies will have regulations that limit importation of certain pharmaceuticals and/or medical supplies. OCOG Medical Services is asked to facilitate the NOC medical teams' efforts to bring the medical equipment and supplies they will need to treat their delegation members during Games-time.

Well ahead of Games-time, Medical Services should gather information related to controls on importation of pharmaceuticals and other medical supplies. Medical Services should then work with the OCOG's Functions that has responsibility for working with the OCOG's official customs broker to review the regulations and identify the governmental agencies involved in this area. NOCs and other constituent groups will be encouraged to work with the customs broker who can facilitate shipments and educate these groups about relevant regulatory controls.

Approximately one year before Games-time, Medical Services should develop an educational memorandum for the NOCs. NOC Services should be responsible for translating and sending the information to the NOCs. This memorandum should provide information about the regulations limiting importation of certain pharmaceuticals or medical supplies and should suggest the NOCs work with the OCOG's official customs broker. Some NOCs may choose not use the customs broker. For NOCs that elect not to use the customs broker, Medical Services should enclose a form with the memorandum that the NOCs can use to pre-submit a list of medical items they plan to bring to the Host City. The NOCs should be instructed to submit the list of medical items to the OCOG six months prior to the Games, to allow time for OCOG Medical Services work with the local customs agency or health ministry to review the list and notify the NOC of any issues. The OCOG's NOC Services will facilitate all correspondence and communication between OCOG Medical Services and the NOCs.

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# 6.3 Health Regulations & Entry Rules, Continued

**Animal Quarantine**

Horses brought into the country for the equestrian events will be subject to certain health restrictions and quarantine periods. OCOG Medical Services should research the animal entry regulations for the host country and inform the NOCs of such regulations.

# 6.4 Health Promotion

**Introduction**

The occasion of the Olympic Games brings an excellent opportunity to reinforce positive health practices within the venue cities. Providing health information to the community and visitors will also help reduce the incidence of preventable illness and injury. Health education messages can be disseminated by the OCOG through certain of their publications as well as to the public through the print and broadcast media.

Health promotion activities can be implemented by the OCOG or the community, and tying such activities to the Olympic movement can reinforce such messages.

**Note of Caution**

References implying Olympic "sponsorship" of health promotion activities cannot be freely adopted. Consult the Technical Manual on Brand Protection to avoid any ambush activity or sponsor conflicts.

**Smoke-Free Environment**

Regardless of the local regulations for smoking, the village and venues should be designated as smoke-free environments.

# 7.0 → Disaster Planning

## Executive Summary

**Introduction**

This chapter describes the elements required for planning and addressing the event of mass casualty or disaster situation.

**Overview**

The Olympic Games bring an influx of visitors and other Olympic participants that should be considered in disaster response planning. Some of the increased mass casualty risks could include (but are not limited to):

- The high-profile media coverage of the Games which increases the risk of potential terrorist-related activities
- Temporary venue structures (i.e. spectator stands, heating/cooling systems in tents, miles of cable and wiring, etc.) could fail, cause accidents, etc.
- The impact of natural disasters (weather or geological) could be increased by the increased population in the venue cities

The OCOG should not, by itself, be responsible for the venue cities' disaster response plans; however the OCOG should be a significant participant in developing disaster response plans. OCOG Medical Services should work with the public health, safety and disaster response agencies involved in disaster response planning, and with other OCOG Functions.

It is important for OCOG Medical Services to understand the authority and control structures that will be implemented during a mass casualty incident (MCI). Generally, non-OCOG agencies will be in charge and should coordinate the OCOG resources at the site of the MCI.

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| 7.2 Mass Casualty Incident - Venue |
| 7.3 Mass Casualty Incident - Outside Venue |

# 7.1 Resources Dedicated to Disaster Response

**Medical Personnel Designated for MCI Response**

The venue cities' existing disaster response plans will have assigned roles for many of the local medical providers. There is bound to be some cross-over with the doctors, nurses, and paramedical staff recruited for the OCOG Medical Programme that also have roles within the disaster response programme. Although these dual roles cannot be totally avoided, the Chief Medical Officer should try to minimize the number of individuals with such dual roles that are assigned to the OCOG medical leadership team.

If a large-scale mass casualty incident would occur, the OCOG must realise that medical resources it had scheduled for an event could be redirected to the MCI. This is not a preventable situation, but the venue management and sport departments should be made aware of this risk. OCOG Medical Services should develop a back-up staffing plan to address this risk if they plan to fortify these caches for heightened Games-time readiness.

**Medical Supply Caches**

The responsible local, regional, or national disaster response agencies should have responsibility for procuring and strategically placing caches of medical supplies that might be needed during a mass casualty event. This is generally not a responsibility of the OCOG, although the host city may negotiate a sharing of the expense with the OCOG.

# 7.2 Mass Casualty Incident - Venue

**Disaster Response Planning**

During the disaster response planning activities, the individuals who would assume the role of incident commander should be briefed accurately about the medical resources that would be available at a venue including all medical staffing, equipment, supplies and pharmaceuticals that will be in place at the venue.

During the planning phase, OCOG Medical Services, venue management, venue security, EMS, and the community-based emergency response agencies will develop a protocol to activate a disaster response. Pre-Games venue training exercises should include disaster response drills.

**Activation of Disaster Response**

Under normal circumstances, the Venue Medical Officer (VMO) has authority over the medical resources at a venue and over the clinical care decisions. This authority covers all venue-based OCOG medical staff whether volunteers or contractors, including EMS and FOP medical response teams. As an example: if spectator stands collapse the medical resources at the venue are not likely to be adequate to treat all of the injured and an MCI should be called. Activation of disaster response protocols should then be initiated through the VCC.

**Incident Command Structure**

In the event of an MCI, the VMO should remain in charge of the medical responders until the incident command structure is put in place, at which time the VMO would relinquish his/her authority and become a resource to the incident commander. The venue-based medical staff and volunteers should understand the command structure and respond as directed.

# 7.3 Mass Casualty Incident - Outside Venue

**Introduction**

The event of a mass casualty incident (MCI) outside of a venue can have significant impact on the community and may have an impact on the Games. An MCI could be of varying size: from a relatively moderate incident involving multiple injured persons to a disaster involving hundreds or more. While some of the issues that have relevance to the Games are described in this section, all OCOG Functions should review the community's response plans for an MCI outside of a venue so that contingencies can be developed.

It is anticipated that in planning for a Games, the host city and country will develop MCI response plans that include strategically located caches of medical equipment, supplies and pharmaceuticals. The community will develop of roster of medically trained staff designated to respond to the MCI. The EMS system may redirect staff and vehicles that may have been designated for dedicated coverage of Olympic venues.

The OCOG's medical headquarters (MHQ) and/or main operations centre (MOC) will work with the MCI command structure to understand the extent of the MCI and the impact on scheduled competition or other Olympic-related events. The MOC will develop a communication protocol to keep relevant Functions informed of the status.

**Relevance for Staffing and EMS**

An MCI may cause the Games to be suspended; certain venues to be put on hold; or may not impact the Games schedule. OCOG Medical Services could be impacted in any of these situations.

### Staffing

The very skill set that the OCOG will look for in developing its staffing for venue medical services (i.e. emergency-trained doctors, nurses, and paramedics) is shared by the community's emergency response team. It is not likely that the OCOG would be able to limit its medical staffing to individuals who are not already designated to either respond to hospital, or to respond to the scene during an MCI. OCOG Medical Services should become familiar with the response teams designated by the community and develop a communication protocol to activate in the event of an MCI. This communication protocol should anticipate varying scope of the MCI:

- If a relatively small MCI occurs, but requires certain OCOG medical staff to respond to the hospital or scene, these individuals should make arrangements for the venue to be notified so that substitute staff can be called in.

Continued on next page

# 7.3 Mass Casualty Incident - Outside Venue, Continued

**Relevance for Staffing and EMS** (continued)

- If a more significant MCI occurs, it may not be possible for individuals to call-in due to congestion of the community's communication system. In this situation, the EMS dispatch system, or others in the Incident Command structure should notify the OCOG's MHQ, so that alternate medical staffing for the venue can be implemented.
- In the event of a huge disaster, the MOC and Incident Command will handle communications. OCOG Medical Services' representative in the MOC should communicate with the Chief Medical Officer, MHQ, and the relevant venue or village medical teams.

*EMS:* Venue-dedicated EMS staff and vehicles are also at risk for being diverted to respond to an MCI. During the planning phase, OCOG Medical Services should work closely with EMS leadership to be sure both groups understand and agree on prioritisation of resources in the event of an MCI. OCOG Medical Services should be sure that the OCOG's Venue Management and Sport functions understand this risk because the diversion of EMS resources could mean an event would have to be delayed until EMS coverage is restored.

**Relevance for Medical Equipment and Supply**

In planning for MCIs inside or outside of a venue, OCOG Medical Services should work closely with community-based, national, and military disaster-response agencies to determine the most appropriate stockpiles of medical equipment, supplies, and pharmaceuticals. Such resources may be deployed for an MCI inside or outside of a venue. These stockpiles or caches can represent a significant cost and the OCOG may be asked to share in covering the expense. OCOG Medical Services will likely be involved in such negotiations, and should make sure any such financial obligations are addressed in the OCOG budgeting process.

# 8.0 → Guarantees & Operational Issues

## Executive Summary

**Introduction**

While the general obligations of the OCOG Medical Programme have been reviewed in previous chapters, this chapter will review some of the issues associated with the planning and operations of the Medical Programme.

**Contents**

This chapter contains the following topics:

| Topic |
|---|
| 8.1 Pre-Games Planning, Organisation, & Resource Development |
| 8.2 Test Events |
| 8.3 Games-time Operations |
| 8.4 Medical Publications, Forms, & Reports |
| 8.5 Miscellaneous Medical Planning |

# 8.1 Pre-Games Planning, Organisation, & Resource Development

**Introduction**

Planning for OCOG Medical Services will start during the bid process, as the Bid Committee gathers information about Games requirements and assesses resources. Information from the IOC Transfer of Knowledge programme will help with preliminary budgeting and planning. This section will discuss some of the issues associated with the pre-Games period, including planning processes, organisational structure, staff recruitment, and equipment and supply procurement/logistics.

**Integration with Community and other OCOG Functions**

- It cannot be stressed enough that OCOG Medical Services should devote the necessary resources and priority with regard to integration. This requires quite a time commitment in terms of meetings and also requires that planning and documentation be shared. This will help ensure common assumptions as each function/agency moves forward in their respective areas of planning.
- The Games represent a huge financial commitment for the host city, and for others in the Olympic movement. Cooperation and optimal use of resources is an absolute necessity. This will mean sharing and compromise. The OCOG should depend on Medical Services to distinguish between "must have" for the health and safety of the Olympic constituents and the community, versus "nice to have" in terms of operational convenience.

**OCOG Medical Staff**

The Chief Medical Officer (CMO) should be appointed approximately 50 to 52 months prior to Games-time. This allows the CMO to study and then attend the Games of the Olympiad or Winter Olympic Games that will be held 4 years in advance of this OCOG's Games. The CMO should be approved by the IOC, and will thereafter work closely with the IOC Medical Director/IPC Medical & Scientific Director and IOC Medical Services Project Manager.

Medical Services' leadership should include expertise in the areas of sports medicine; primary and specialty medical practice; mass gathering health management strategies; public health; EMS; disaster response; veterinary medicine (summer Olympic Games and summer and winter Paralympics); equipment and supply logistics; administration; and operations. This core medical team will typically be a mix of full-time and part-time staff. Other individuals may advise OCOG Medical Services but may not have an employment or contractual relationship to the OCOG.

Continued on next page

# 8.1 Pre-Games Planning, Organisation, & Resource Development, Continued

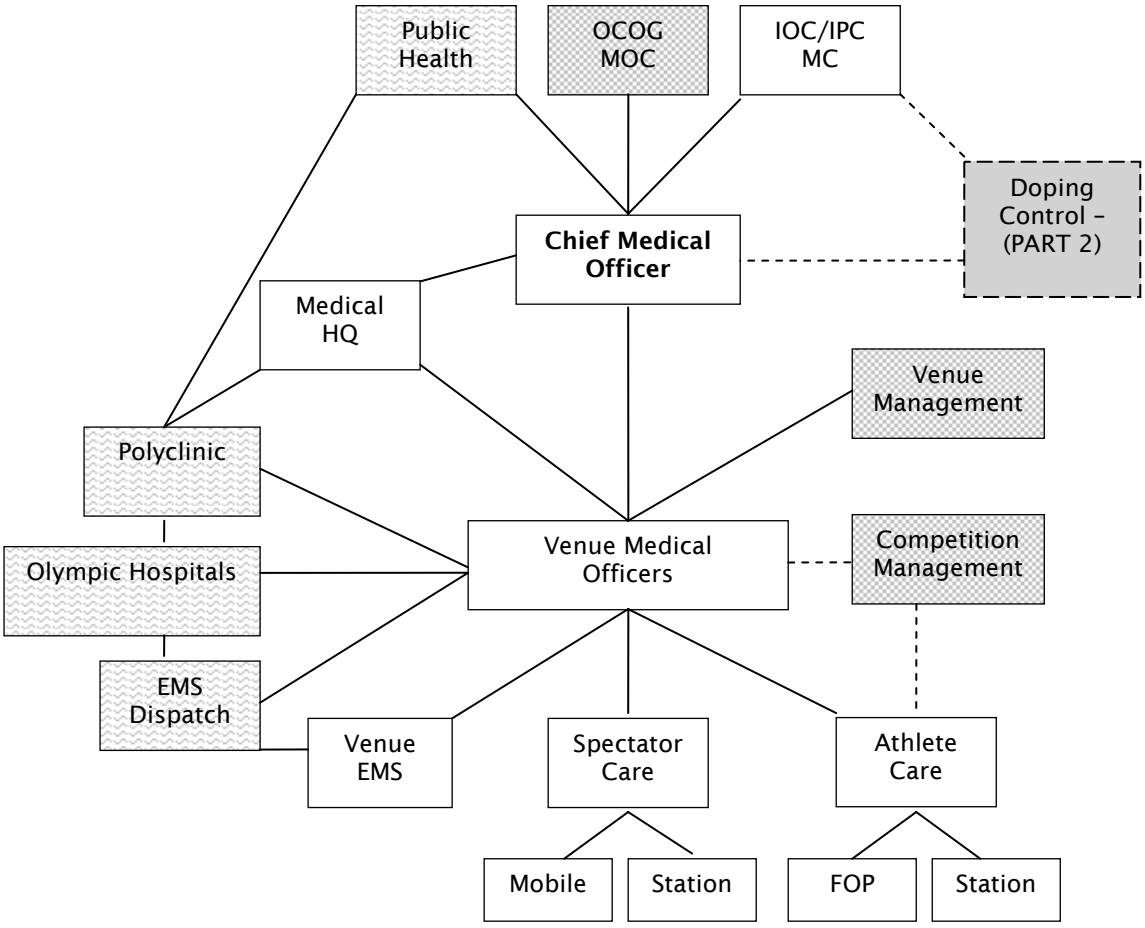
**OCOG Medical Staff** (continued)

The core medical team may evolve as planning progresses. In the earliest phases of planning, medical team members may do most of their work in the areas of their own specialization or expertise – defining requirements for the various aspects of the Medical Programme (i.e. field-of-play response protocols, medical equipment and supplies, staffing plans, etc.) One year out (or more), Venue teams should be developed, and OCOG Medical Services should be prepared to identify medical representatives to participate in venue-based planning. Early on, this is likely to be assigned members of the core medical team. Eventually Medical Services will need to appoint a Venue Medical Officer for each site. Please refer to the general venue-based Medical Services structure below. The overlapping matrices for reporting and communication should be considered when determining their organisational structure and staffing plans for the Medical Programme.

# 8.1 Pre-Games Planning, Organisation, & Resource Development, Continued

**Relationship Chart**

The below chart represents the organisational structure and staffing plans for the Medical Programme.

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# 8.1 Pre-Games Planning, Organisation, & Resource Development, Continued

**Medical Volunteers**

**Staffing Requirements and Recruitment**

In determining the number of medical volunteers required, the OCOG should request access to reports from prior Olympic Games to review the number of actual medical encounters. Staffing plans should be kept to a minimum, but should support:

- The anticipated volume of care based on prior Games experiences
- Adequate FOP and mobile medical coverage to ensure a prompt response

Staffing plans should be completed 2 years prior to the Games to allow time for recruitment and screening activities.

**Consideration of Community-based Health Resources** △

The level of medical services for the community must not be compromised during Games-time. Capacity issues must be addressed during the planning phase to ensure optimal use of community-based health resources and appropriate level of care for the community and Olympic-related patient populations.

**Recruitment Strategies**

Medical staffing for past Games has utilized numerous recruitment strategies, some of which are listed below:

- VMO recruitment: Use objective-based criteria and skill sets in the selection of VMOs and other leadership positions, even though there will be pressure for political and/or social obligations in making these appointments.
- Core medical team: It may be difficult to recruit expert staff for these *temporary* positions, however, it is crucial that candidates devote adequate time and energy to OCOG Medical Services responsibilities. Do not compromise on candidates that cannot commit adequate time away from their community-based jobs.
- Medical volunteers will be recruited from a limited pool of skilled candidates unlike the OCOG's general volunteers. This means Medical Services will probably need to implement its own recruitment and selection processes and timelines. Be sure that the OCOG's Human Resources and Volunteers functions understand this.
- Medical and health employers in the community should be involved in planning for OCOG medical staffing. Medical Services should cooperate and support the hospitals, clinics, and private practices so they can adapt scheduling to allow for volunteers to take time away from their regular duties.
- If limited capacity of the medical community results in the OCOG needing to recruit Games-time medical staff from outside the area, OCOG Medical Services should understand relevant licensing or other regulatory issues (see section 1.3 in this manual).

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# 8.1 Pre-Games Planning, Organisation, & Resource Development, Continued

**Recruitment Strategies** (continued)

- Many of the venues will have existing medical response teams that cover regular season activities and competitions. When appropriate, Medical Services should recruit these same individuals for Games-time to take advantage of their experience and expert knowledge of the relevant sport. When existing venue teams are recruited, it is important for them to understand that Olympic Games have special requirements and existing venue response plans will have to be adapted for Games-time, under the authority of the IOC, the relevant IF, the OCOG Chief Medical Officer, and other relevant OCOG Functions.
- To optimise the quality of medical care, and also to minimise uniform and training requirements, the OCOG should try to get the maximum number of shifts from each medical volunteer and reduce the overall number of medical volunteers.
- Resources for Games-time staffing include colleagues of the core medical team and VMOs, hospitals that may partner with specific venues or the village, medical volunteer associations, medical professional organisations, and medical staff that sign up through the OCOG general volunteer recruitment initiative. When assessing medical volunteer applicants, there should be a process for evaluating skill sets, experience, and proficiency.
- In past Games, some OCOG Games-time medical staff received limited compensation for their Games-time shifts. This distinction typically moves them from volunteer positions to "contractor" positions. Operationally, they would be treated as volunteers.

**Medical Equipment & Supplies**

OCOG Medical Services should consult with several OCOG Functions in determining the procurement process and timeline for medical equipment, supplies and pharmaceuticals. The other Functions include (but may not be limited to): Marketing, Logistics/Procurement, Security, and Budget.

### Marketing

The right to be referred to as the "Official Sponsor" of any product requires a company to negotiate a significant marketing contract with the IOC (Top Sponsors) or the OCOG (OCOG sponsors, licensees, suppliers). Medical Services should determine which medical supplies are required for the Games programme, but must refer the manufacturers to the Marketing function is there is potential interest in a marketing agreement. Referrals like this are a key opportunity for Medical Services to help reduce costs associated with the Medical Programme and to increase revenues for the OCOG.

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# 8.1 Pre-Games Planning, Organisation, & Resource Development, Continued

**Medical Equipment and Supplies** (Continued)

### Logistics/Procurement

OCOG Medical Services should work closely with the Logistics and Procurement functions because medical equipment, supplies, and pharmaceuticals may have special handling procedures. It may be possible for assets to be borrowed from community-based health facilities, or they may be sold or donated to the community-based health facilities following the Games-period. The potential for accessing medical supplies from the community health system may require special procurement, security and handling. Segregated or entirely separate storage areas and special procedures may be required for stocking and replenishment of supplies.

During the load-in of the venues, Medical Services should remember that venue medical stations may be in very remote areas. After entering the venues, supplies may have to be transported via snowmobile, carts, or by hand. This should be considered when determining how much set-up can be accomplished in the staging area and what set-up will need to occur at the venues.

Medical volunteers will need to know what medical equipment, supplies, and pharmaceuticals are available for their use at the venues. This means shelves or bins should be labelled and inventory lists should be provided in the medical station.

### Security

Security will be heightened at the time of the Games, which will impact the set-up and delivery of supplies. The OCOG's Security Function will survey the warehousing areas for pre-Games staging of supplies. There will be special security for staff and vehicles that enter the venues. When planning for replenishment of medical supplies or pharmaceuticals, considerations include vehicle accreditation, security inspections, and registration at venue "Material Transfer Areas."

### Budget

Medical supplies represent a significant cost for the OCOG. Requirements should be defined early to allow Medical Services, Logistics, and Marketing the opportunity to get items loaned, donated or negotiated into marketing agreements.

# 8.2 Test Events

**Introduction**

The host city will sponsor a number of competition events in the years preceding the Games. In the one to two year period before the Games, some of these competitions will be designated as pre-Games "Test Events" which will allow various OGOC Functions to implement and assess the effectiveness of their Games-time operational plans prior to the actual Games "go-live." These test events take substantial planning hours and require volunteers, equipment, and supplies to be in place well in advance of Games-time.

**Planning Timelines**

The test events will consume much of the OCOG Medical Services' core team resources. In developing the planning timelines, Medical Services should consider that many Games-time planning activities may be disrupted during the test event season.

**Facilities**

The venue build-out is likely to be limited for a Test Event, so the medical station(s) may not be the same as planned for Games-time. If possible, the OCOG should build out at least one temporary medical station according to the Games-time design, so that its functionality can be assessed.

**Equipment & Supplies**

Much of the equipment and supplies needed for test events may be able to be reused at Games-time. This presents a challenge in terms of what portion of Games-time medical equipment and supplies should be ordered in time for test events and where they can be stored in between the test event and Games-time.

Some equipment (i.e. stretchers, toboggans, exam tables and training room items) may be borrowed from the venue for the test event. If this is the case, the OCOG Function that is responsible for developing the venue contract for the test event should be informed of the medical items that should be requested from the venue.

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# 8.2 Test Events, Continued

**Staffing & Staff Training**

Test events represent an excellent opportunity to familiarise the VMOs, venue-based medical volunteers, and the core medical team with event operations; communication protocols; competition rules and their impact on field of play response protocols. In addition, the VMOs and athlete medical teams will have the opportunity to meet some of the international medical staff that will participate on the NOC medical teams at Games-time. Test events allow the NOC team doctors and physio-therapists to develop an understanding of and confidence in the OCOG's Medical Programme. At the same time, the OCOG's medical team can learn more about the sport-specific medical risks and treatments for the athletes.

Not all medical volunteers will have the opportunity to participate in a test event, but the more that can participate, the better prepared they will be. Unfortunately, there will be significant budgetary constraints associated with test events, which will limit the number of volunteers allowed from each Function. This challenge will require collaboration and compromises among each of the Function and OCOG management. Medical Services will have to negotiate a balance between optimal training of volunteers and the minimum staffing required for health and safety of the test event participants

# 8.3 Games-time Operations

**Introduction**

In the transition period between pre-Games planning and Games-time operations, Medical Services will implement the OCOG's "venuisation" process. Venuisation begins when venue-based teams are created. Matrix reporting structures are implemented with accountability to *functional leadership* (i.e. the CMO), and also to *venue management*. Venue teams will be operational during the test events, allowing evaluation of communication and decision-making protocols.

As Games-time nears, OCOG Medical Services should develop their command and coordination resources. This will include assigning medical representation for the OCOG's main operations centre (MOC) and setting up a medical headquarters (MHQ) where core medical team resources can coordinate Games-wide medical activities such as:

- OF medical case management
- Medical equipment and supply replenishment
- Staffing (if venue-based teams exhaust their own back-up staffing resources)
- Medical surveillance and reporting
- Communication

**Organisational Structure**

Limited resources will require OCOG Medical Services to develop efficiencies in its staffing plans, but medical staffing should also consider "worst case possible" staffing needs. The best medical staffing plan will fall somewhere in-between.

Medical Services, in consultation with all the stakeholders related to the medical programme, should develop Games-time communication strategies and assign individuals on the core medical team to support them. Stakeholders include:

- IOC MC
- Medical Services core team
- Venue medical officers
- NOC team doctors
- Functional managers at the MOC
- OCOG media relations
- OCOG Main Operations Centre
- Public health officers
- Hospital Olympic liaison officers (HOLOs)
- EMS dispatch
- Disaster response agencies

Continued on next page

# 8.3 Games-time Operations, Continued

**Medical Headquarters and MOC**

The OCOG's MOC should be staffed 24 hours a day, 7 days a week during the Games operational period. The MOC will require a designated representative of Medical Services to be available at any time during the Games, although on-site presence of the medical representative at the MOC should be determined locally and may vary depending on the Games-time activities.

The medical headquarters (MHQ) structure and location should ensure that the core medical team can respond quickly and efficiently to all aspects of the Medical Programme throughout the Games period. Because several of the medical programmes will run 24 hours a day, MHQ resources should be available to support them around the clock. This may be accomplished with 24-hour on-site MHQ coverage or by on-call MHQ staffing.

**Language Services**

With worldwide Games participants, effective communication with patients can be a challenge. OCOG Medical Services must plan for language assistance at the village polyclinic; at the media centres and official hotels; at the Olympic hospitals; and at the venues. Venue language assistance should be available to mobile medical responders, field of play responders, and medical station staff.

In host cities where many of the medical volunteers do not speak English or French, the need for interpreters will be greater. English or French proficiency may be a significant criterion for the recruitment and scheduling of medical volunteers.

The OCOG's Language Services Function will provide interpreter services at the venues, official hotels, village, and media centres, but they may not be dedicated specifically to Medical Services. Language Services should prioritise response for medical situations requiring an interpreter, but Medical Services should also plan for use of Language Line services available over the telephone. For effective use of Language Line services, appropriate telecommunications equipments must be readily available (cell phones and/or land-line speaker phones).

# 8.4 Medical Publications, Forms, & Reports

**List of Medical Publications, Forms, and Report**

There are a number of medical publications and reports that OCOG Medical Services will be responsible for. Some of these are listed below:

- Medical Care Guide, Technical Doping control procedures, and the Drug Formulary Guide
- Medical chapters or references for other Functions' publications
- Pre-Games planning reports and a Post-Games summary report
- Official operational documents (patient-care documentation, doping control forms)
- Day-to-day operations reports and forms

The table below summarizes many of the required publications, forms and reports. OCOG medical services should know that requirements can evolve during the planning periods, and the relevant stakeholders will have to be consulted right up to Games-time.

| Item | General Description | Approval | Comment |
|---|---|---|---|
| Medical Care Guide | Small guide in which the Health Care Programme is described. | IOC Medical Director or IPC Medical & Scientific Director | Distribute to NOCs, IFs, and IOC Members 6 months prior to Games. |
| Medical Care "Summaries" | Short summaries for the Chef de Mission manual, Olympic Guide, Athletes Guide, Ticketing brochures, and the OCOG Customs and Importation Guide. | CMO and Functions that "own" each publication | Medical Services should meet with OCOG Functions to identify publication dates. |
| Operations Manuals | Reference manuals for review by medical volunteers, contractors, staff and EMS – will include specific guidelines, policies, and procedures. | CMO and relevant operational stakeholders | Medical Services will develop a generic manual - then the VMOs should review/revise for unique aspects of their venue. |
| Volunteer Training Materials | The OCOG must provide written training materials for the workforce, in addition to didactic and practical training sessions. The OCOG's Games Volunteers function will coordinate publication of Volunteer Training Manuals. | CMO and Games Volunteer function | All functions submit content for training manuals. Medical Services may choose to develop additional training materials. |

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# 8.4 Medical Publications, Forms, & Reports, Continued

**List of Medical Publications, Forms, and Report** (continued)

| Item | General Description | Approval | Comment |
|---|---|---|---|
| Medical Encounter Forms | These are forms for documentation of medical care. Medical encounter forms should be reviewed with public health authorities to ensure regulatory compliance for documentation of care *and* identification of symptoms relevant to public health surveillance*. Please see **Clinical Reporting** section below.<br><br>The IOC MC may also have data requirements to monitor preventable athlete injuries. This may require additional documentation beyond what is otherwise required. | CMO, Public Health Agencies, IOC Medical Director, IOC MC working groups (dental and physiotherapy) or IPC Medical & Scientific Director | Electronic Medical Records (EMR) may be an option, but limited IT resources may prohibit such technology solutions. |
| Operational Forms | These include unofficial, operational forms that support day-to-day operations, (i.e. medical supply inventory management, VMO end-of-shift reports, notification of significant medical event). | Core Medical Team | Review forms for efficiency, effective communication, and collection of data for post-Games reports. |
| NOC Physician Registration Forms | Registration forms for team physicians and paramedical staff must be sent to the NOCs approximately 6 months prior to Games-times and returned to OCOG three months prior to Games-times, to allow time for process registrations and verifying licensure. | The Health Ministry or other governing body. | NOC Services will support translations and distribution of NOC physician registration forms. |
| Forms for NOC Importation of Medical Supplies | A form to be sent to NOCs approximately one year prior to Games-times and returned to OCOG six months prior to Games-times to allow time for review of items for importation and communication regarding any issues or problems with proposed imported items. | | NOC Services will support translations and distribution of NOC medical importation review forms. |

Continued on next page

# 8.4 Medical Publications, Forms, & Reports, Continued

**List of Medical Publications, Forms, and Report** (continued)

| Item | General Description | Approval | Comment |
|---|---|---|---|
| Drug Formulary Guide | The guide will list all medications available through the OCOG's Medical Programme (branded name and generic name) as well as its status with regard to Doping Controls (i.e. restricted or prohibited). This guide is distributed to the NOCs and IOC Members six months prior to the Games. | IOC Medical Director or IPC Medical & Scientific Director | Copies should also be distributed to the venue athlete medical stations, the polyclinic, and the Olympic Family Hospitals. |

**Clinical Reporting**

Data from the medical encounter reports should be entered into a Medical Encounter software tracking system. The IOC may have a designated software vendor already in place, or the OCOG may develop its own software solution. The IOC Medical Director and/or the OCOG Marketing function can provide information about software options.

Once critical elements of the medical encounter data are entered into a database, reports can be generated for:

- Public health surveillance
- Operations management of the medical teams
- Updates to the OCOG and IOC MC leadership

The clinical reports are of great value during Games-time, but also provide helpful information for future Games planners. See section on Public Health Surveillance in this manual.

**Operations Reporting**

OCOG Medical Services should create operational reports that support the day-to-day operations and management of the venue-based medical teams. These can be developed at the discretion of the core medical team and CMO. Medical Services will also be asked to submit certain daily summaries to the MOC and the IOC MC/ IPC Medical & Scientific Department.

# 8.5 Miscellaneous Medical Planning

**Veterinary Services**

For the equestrian events of the summer Olympics, NOCs' horses should be transported to the host city or the venue or city which has been identified by the IOC Executive Board to host the Equestrian Olympic Events in due time to allow for necessary quarantine. Once the animals are released from quarantine, OCOG Medical Services should have available skilled veterinary doctors to respond to illness or injuries of these animals following FEI rules:

- Veterinarian staffing during events
- On-call veterinarian services
- Veterinary hospital services

# Part II →
# Doping Control

## Executive Summary

**Introduction**

This chapter outlines the General Principles, roles and responsibilities and key documents and structures related to the OCOG's Doping Control Programme.

**Key Responsibility**

The Doping Control Programme is responsible for the planning and delivery of the infrastructure necessary to implement the Doping Control Programme at the Olympic Games and the Paralympic Games, in accordance with the requirements of the IOC, IPC and in compliance with provisions of the World Anti-Doping Code and accompanying International Standards.

**Doping Control Programme**

The OCOG, at its expense, shall put into place and carry out, doping controls, under the authority of the IOC/IPC, in accordance with instructions received from the IOC/IPC, and the provisions of the World Anti-Doping Code and the IOC Anti-Doping Rules/IPC Anti-Doping Code that will be applied by the IOC/IPC, at the time of the Games.

**Contents**

This part contains the following topics:


| Topic |
|---|
| 9.0 General Principles |
| 10.0 Test Distribution Plan |
| 11.0 Doping Control Workforce |
| 12.0 Venue Requirements |
| 13.0 Testing Process |
| 14.0 Laboratory Requirements |

# 9.0 → General Principles

## Executive Summary

**Introduction** This chapter describes the general principles regarding Doping Control in relation to an OCOG.

**Contents** This chapter contains the following topics:

| Topic |
|---|
| 9.1 Overview |
| 9.2 Roles & Responsibilities of Organisations |
| 9.3 Key Doping Control Documents |
| 9.4 Doping Control Programme Structure |

# 9.1 Overview

**Issue of Doping**

Doping is an historic and ongoing problem facing athletes and the broader sporting community. The issue of doping is complex and therefore the solution/s to deal with it must also reflect this complexity.

### Respond to Current Issues

It is important that each OCOG has an opportunity to reflect on the current Doping Control issues the athletes are facing to ensure that the Doping Control Programme developed and implemented by the OCOG with the IOC is relevant to the current situation.

**Objectives**

An OCOG's objective should be to plan and deliver a Doping Control Programme, which is conducted in accordance with the relevant rules and correct procedures to ensure that an Athlete who breaks the rules is able to be sanctioned by the IOC/IPC and relevant International Federation.

### Minimise Impact on Athlete

It should also take the rights of the Athlete into consideration and where possible minimise the impact on the Athlete at this significant time in the Athletes' career by providing the appropriate resources to conduct the programme efficiently, professionally and with sensitivity.

**Background**

### Atlanta 1996

Up until and including the Atlanta Olympics 1996 (with the exception of some blood sampling done at Lillehammer Winter Olympics in 1994, and alcohol breath testing done for a limited number of sports in all recent Games) a Games Doping Control programme involved the collection of urine samples post or "In-Competition", primarily from medal winners.

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# 9.1 Overview, Continued

**Background** (continued)

### Sydney 2000 and Salt Lake City 2002

In Sydney 2000 and Salt Lake City 2002 the Doping Control Programme primarily involved the collection of urine samples "In-Competition" however in response to the current doping issues there was also an Out-of-Competition testing programme and blood sampling, relating to the prohibited substance, Erythropoietin (EPO).

### Athens 2004

In Athens 2004, while the programme primarily involved the collection of urine samples there was also a significant increase of blood sampling in both the pre-Games (Out-of-Competition) phase and the post-competition phase relating to three prohibited substances: Human Growth Hormone (hGH), Haemoglobin Based Oxygen Carriers (HBOCs) and Blood Transfusions. As well as medal winners and some random selections, there was also an increased use of Target Testing.

**Chain of Custody of the Sample**

It is vital that the Testing processes are fully understood by all involved, and that the "Chain of Custody" of the sample is not broken.

Failures in processing tests properly could result in high profile challenges, which will reflect poorly on the OCOG.

### Key Factors effecting Chain of Custody

- Recruitment and training of doping control personnel
- Notification processes
- Sample collection and sealing processes
- Sample collection equipment
- Courier system and sample transport processes

Each factor is a vital link in the chain to ensure a successful programme.

**Comprehensive Programme: Information Strategies**

As part of the commitment to the World Anti-Doping Code, it is also important that an OCOG include information strategies in addition to the more traditional testing strategies.

# 9.2 Roles & Responsibilities of Organisations

**Introduction**

This chapter describes the roles and responsibilities of the organisations involved with the Doping Control Programme at the Games. It also summarises who is responsible for the various parts of the doping control process.

**World Anti-Doping Code**

As stated in the Olympic Charter, the World Anti-Doping Code is mandatory for the whole Olympic Movement.

**Reference World Anti-Doping Code**

The World Anti-Doping Code sets out the roles and responsibilities of the following organisations in respect of Doping Control programmes, including the Olympic and Paralympic Games:

- IOC
- IPC
- International Federations
- National Olympic Committees and National Paralympic Committees
- National Anti-Doping Organisations
- Major Event Organisations
- WADA
- Athletes
- Athlete Support Personnel
- Governments

**Doping Control Programme**

The OCOG, at its expense, shall put into place and carry out, doping controls, under the authority of the IOC, in accordance with instructions received from the IOC, the provisions of the World Anti-Doping Code and the IOC Anti-Doping Rules that will be applied by the IOC at the time of the Games.

**Compliance with International Standards**

The OCOG should ensure that the Doping Control Programme's facilities, equipment, processes and procedures meet the International Standards required by the World Anti-Doping Code, referenced in the IOC Anti-Doping Rules and IPC Anti-Doping Code.

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# 9.2 Roles & Responsibilities of Organisations, Continued

**Organisations Involved**

This table outlines the specific organisations involved in Doping Control at the Olympic Games and Paralympic Games and their respective key roles and responsibilities.

| ORGANISATION | KEY ROLE/RESPONSIBILITY |
|---|---|
| OCOG Doping Control Programme | Plan, establish and manage the infrastructure to enable the Doping Control Programme to be implemented, particularly the Testing stages of the Doping Control process.<br><br>The Doping Control Programme is also responsible for the collection of samples from the horses competing in the Equestrian events. |
| IOC President/Executive Board<br>IPC Governing Board | The IOC and IPC are responsible for the Doping Control programmes conducted at the Olympic and Paralympic Games respectively.<br>They are specifically responsible for managing the results of the testing and imposing appropriate penalties for Doping Control rule violations arising from their respective Games.<br>They may delegate the hearing responsibility to another body. |
| IOC Medical Director<br>IOC Medical Commission | Oversee the planning and delivery of the Doping Control Programme to ensure it is being conducted in accordance with the IOC Anti-Doping Rules. |
| IPC Medical and Scientific Director<br>IPC Anti-Doping Committee | Oversee the planning and delivery of the Doping Control Programme to ensure it is being conducted in accordance with the IPC Anti-Doping Code |
| IOC/IPC Therapeutic Use Exemption Committees | Determine if an athlete is allowed to use a prohibited substance or method. |

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# 9.2 Roles & Responsibilities of Organisations, Continued

**Organisations Involved** (continued)

| ORGANISATION | KEY ROLE/RESPONSIBILITY |
|---|---|
| International Federation (IFs) | Provide input to the OCOG/IOC re the Test Distribution Plan for their sport.<br>Be informed about any Doping Control rule violation in their sport to be able to enforce longer-term sanctions.<br>Test Event Doping Control Programmes are conducted under IF jurisdiction and Doping Control policies. |
| IF Doping Control Representative | Oversee the doping control processes at their competition venue for their respective sport. |
| National Olympic Committees - NOCs<br>National Paralympic Committees - NPCs | Ensure all Athletes and Athlete support personnel within the team are aware of their Doping Control responsibilities, and in particular are informed about the contents of the Prohibited List. |
| Athletes<br>Athlete Support Personnel | Should be aware that by participating in the Games that there is a possibility of being selected for one or more doping controls in the lead up to and during the Games.<br>Be aware of the Prohibited List and consult with appropriate medical personnel prior to ingesting any substance. |
| World Anti-Doping Agency – WADA | WADA has been involved in the following programmes at recent Games:<br>• Athlete Outreach (Education) Programme<br>• Independent Observer Programme<br>• Support the delivery of the IOC/IPC OOC Testing programmes |
| National Anti-Doping Organisation (NADO) | An established NADO may be able to provide expertise to the OCOG, particularly with regard to experienced planning and field doping control personnel. |
| WADA – Accredited Laboratory | A WADA-Accredited Laboratory will provide the analytical services required by the OCOG/IOC/IPC. |

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# 9.2 Roles & Responsibilities of Organisations, Continued

**Doping Control Process** The following table describes the different parts of the Doping Control process and who is responsible for each part

| | Part of the Process: | Key Responsibility: | Supported By: |
|---|---|---|---|
| Testing Phase | 1. Test Distribution Planning | OCOG Doping Control Programme | IFs – consultation<br>IOC/WADA/OCOG Task Force<br>IOC/IPC - approval of Plan |
| | 2. Sample Collection | OCOG Doping Control Programme | IOC/IPC/IF Doping Control Representatives |
| | 3. Sample Handling | OCOG Doping Control Programme | IOC/IPC/IF Doping Control Representatives |
| | 4. Sample Transport to Lab | OCOG Doping Control Programme | |
| Post-Testing Phase | 5. Laboratory Analysis | Laboratory | IOC Medical Commission<br>Laboratory Experts<br>IPC Anti-Doping Control Committee |
| | 6. Results Management | IOC<br>IPC | IF – for long term sanctions<br>OCOG support – if required |
| | 7. Hearings | IOC<br>IPC | IF – for long term sanctions |
| | 8. Appeals | Court of Arbitration for Sport | IOC/IPC |

# 9.3 Key Doping Control Documents

**Introduction** This table outlines the key documents relevant to the Doping Control Programme:

| Name of Document | Brief Description |
|---|---|
| World Anti-Doping Code | The Code is the fundamental and universal document upon which the World Doping Control Programme is based. |
| International Standards<br>• Testing<br>• Laboratories<br>• Prohibited List<br>• Therapeutic Use Exemptions | The listed Standards are for different technical and operational areas within the Doping Control Programme.<br>Adherence to the International Standards is mandatory for compliance with the Code. |
| Models of Best Practice<br>• Test Distribution Planning Guidelines<br>• Sample Collection Personnel: Recruitment, Training, Accreditation and Re-Accreditation Guidelines | The listed Models are more specific technical documents and guides, which are recommended but are not mandatory. |
| IOC Anti-Doping Rules [applicable for each Games edition] | The specific Doping Control rules written in compliance with the Code and for application at the Olympic Games. |
| IPC Anti-Doping Code | The Doping Control policy of the IPC applicable for all Paralympic Games and other IPC sanctioned competitions. |
| Doping Control Guide [for Paralympic Games] | A Guide detailing the Testing processes to be implemented at the specified Paralympic Games. |

# 9.4 Doping Control Programme Structure

**Introduction** This chapter describes the organisational structure of the Doping Control Programme.

**Single Programme** It is recommended that the OCOG have a single Doping Control Programme responsible for both the Olympic and Paralympic Games Doping Control Programmes.

**Major Deliverable** An effective working structure that enables the OCOG to successfully deliver its Doping Control Programme.

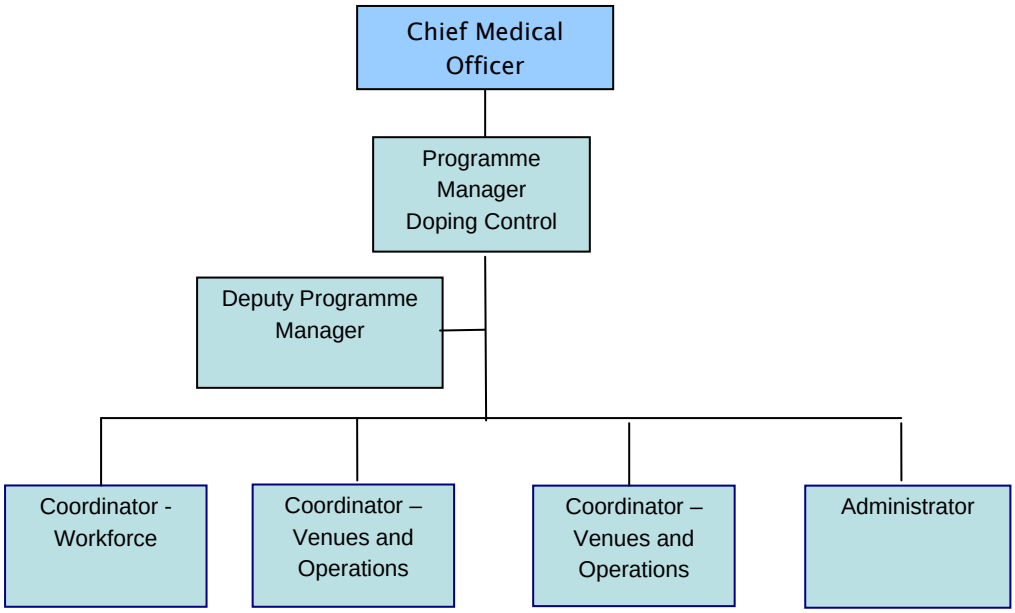
# 9.4.1 Historical Example - Sydney 2000

**Introduction**

This section outlines the paid staff structure of Sydney 2000 Doping Control Programme.

**Sydney 2000 Programme Structure**

The following diagram illustrates the programme structure for the Sydney 2000 Doping Control Programme.




**Adjustment to Structure**

Due to her competencies and the workload of the number of Venues to be covered, the Administrator was also responsible for five Venues.

**Additional Positions**

Due to the workload, there were three additional paid positions added prior to Games time as outlined in the following table.

| Timing | Position | Comment |
|---|---|---|
| G-2 to G | Blood Sampling Coordinator | Recruited in response to the decision to collect blood samples at the Sydney Olympics. |
| G-1 to G | 2 Assistants | Recruited to help primarily with the communication and management of the volunteers, and general administrative tasks |

Continued on next page

# 9.4.1 Historical Example - Sydney 2000, Continued

**Comment**

The amount of staff outlined in this chapter was adequate to get the job done due to the significant Doping Control experience and the dedication of the team, however, with the need to cover all Venues in the planning periods and the additional complexities of blood sample collection and out-of-competition testing, it is recommended that at least two more staff members, and preferably three, are required and all positions should start a little earlier than in Sydney.

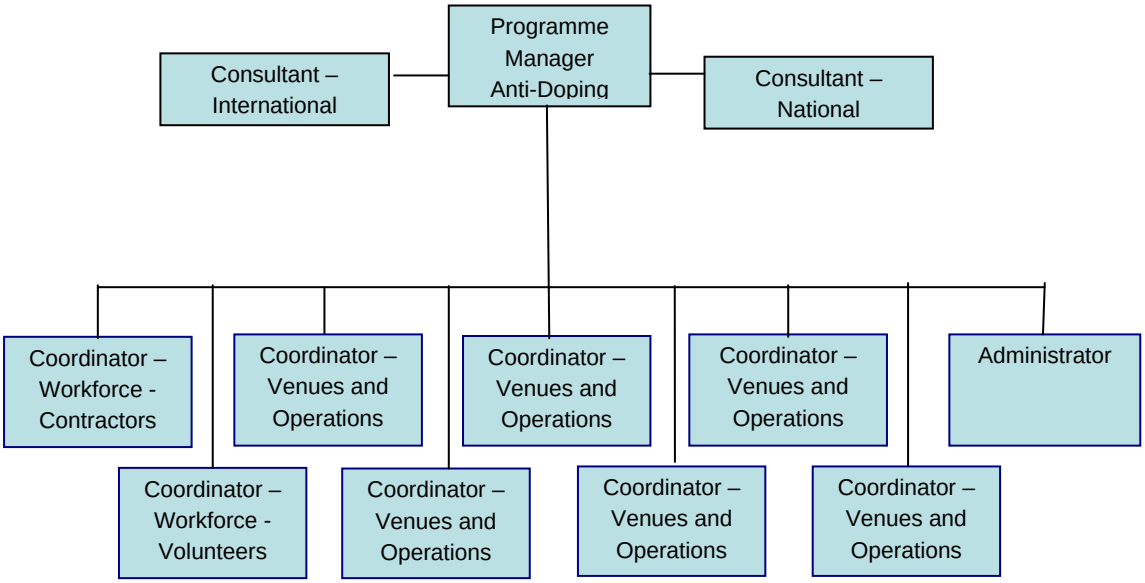
# 9.4.2 Historical Example - Athens 2004

**Introduction**

This section outlines the staff structure of Athens 2004 Doping Control Programme.

**Athens 2004 Programme Structure**

The following diagram illustrates the structure for the Athens 2004 Doping Control Programme.



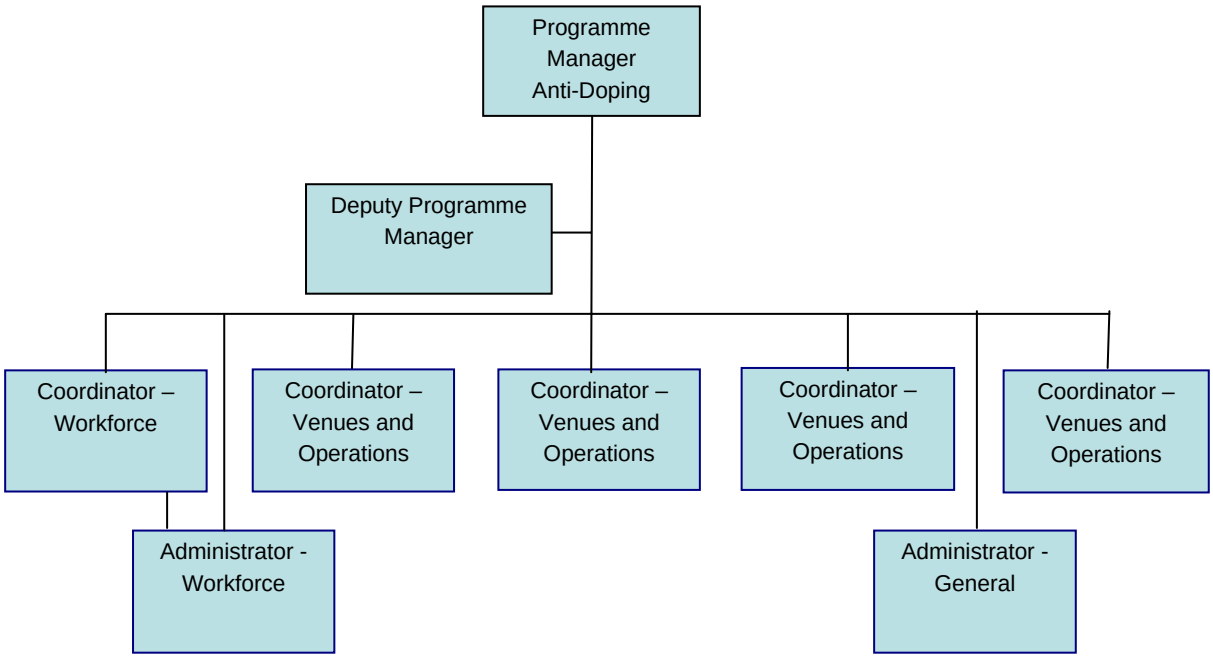
# 9.4.3 Recommended Structure for OCOG Doping Control Programme

**Introduction**

This section outlines the recommended structure for a Games Doping Control Programme.

**Recommended Structure**

The following diagram illustrates the recommended minimum structure for the Doping Control Programme.



# 9.4.4 Staff Position Profiles for Recommended Structure

**Introduction** This section describes the position profiles of the recommended structure.

**Position Profiles** The following table outlines the key responsibilities for the recommended positions as illustrated earlier and the recommended timing of the commencement of these positions.

| Position | Timing | Responsibilities |
|---|---|---|
| Programme Manager | G- 54 months (initially part-time or resource from NADO)<br>Fulltime no later than G-42 months | • Develop and implement Plans: Strategic, Concept of Operations; Operational, Generic Venue Operational Plans;<br>• Participate in initial Venue Planning Teams;<br>• Manage budgets;<br>• Provision of reports as required;<br>• Develop Test Distribution Plan<br>• Liaise with IOC Medical Director, IPC Medical & Scientific Director, International Federations; National Olympic Committees and WADA;<br>• Manage Doping Control Programme and staff;<br>• Initial key link with other Programme and Functions;<br>• Develop and implement agreements with the Laboratory and the NADO (if one exists);<br>• General Test Event planning;<br>• Develop initial sport specific Doping Control operational plans;<br>• Liaise and provide information to the Media; and<br>• Monitor developments in Doping Control, which may impact on programme. |
| PM without Games Experience | G-50 months | • Should be recruited in time to attend the preceding Olympic and Paralympic Games |
| Administrator | G- 40 months, or 2 months after PM starts | • Provide administrative support to the Programme Manager and other staff;<br>• Coordinate travel and accommodation bookings;<br>• Process purchase orders and other financial requirements;<br>• Maintain files and filing system;<br>• Coordinate audio-visual, conference phones, room bookings, catering etc. for all training sessions (until Workforce Administrator starts) and meetings;<br>• Undertake special projects and activities for the Programme Manager as required;<br>• Prepare and coordinate the Programme's publications. |

Continued on next page

# 9.4.4 Staff Position Profiles for Recommended Structure, Continued

**Position Profiles** (continued)

| Position | Timing | Responsibilities |
|---|---|---|
| Coordinator – Workforce | G -36 | • Develop field operations position profiles;<br>• Source and recruit Doping Control personnel;<br>• Coordinate and implement the training of personnel;<br>• Source and manage accommodation for field personnel;<br>• Manage field personnel, including day to day liaison;<br>• Schedule shifts for all personnel;<br>• Ensure appropriate accreditation of personnel;<br>• Recruit, coordinate and evaluate personnel for the Test Events; and<br>• Manage recognition and celebrations. |
| Deputy Programme Manager | G – 30 | • Develop systems and procedures for the Doping Control Programme;<br>• Oversee the recruitment and training of Doping Control personnel;<br>• Manage Paralympic specific components in the training programme<br>• Develop the Doping Control training video;<br>• Coordinate and implement the Test Event programme;<br>• Coordinate and implement the pre-Games/Out-of-Competition testing programme;<br>• Develop Operations Manuals, forms and other publications for Doping Control personnel;<br>• Develop information resources for athletes and teams including the Technical Doping control procedures;<br>• Develop Command Centre facility operations;<br>• Manage the transition process between the Olympic and Paralympic Games;<br>• Assist Programme Manager, as required.<br><br>Note: There should be some flexibility of tasks between Programme Manager and Deputy PM depending on background and skills of each person. |

Continued on next page

# 9.4.4 Staff Position Profiles for Recommended Structure, Continued

**Position Profiles** (continued)

| Position | Timing | Responsibilities |
|---|---|---|
| Coordinator – Venues and Operations<br>(4 positions) | G – 30 | Venues should be split between the four (4) Coordinators on a geographical basis within the Host City and each Coordinator will:<br><br>• Represent the Doping Control Programme in the venue based planning teams to ensure set up of appropriate Doping Control Stations in each Competition Venue and the Village Polyclinic;<br>• Implement the Test Event Doping Control Programme at allocated venues;<br>• Oversee the set up, fit out and all related requirements for each Doping Control Station at the allocated venues, including any Paralympic Transition requirements where relevant;<br>• Develop sport specific doping control operational plans;<br>• Prepare Sport Specific Policy and Operations folders for allocated Venues.<br><br>The following areas should be split between the four (4) Coordinators to initially establish the Doping Control Programme's generic needs and once these are established the specific Venue needs are then handled by the designated Coordinators (as above):<br><br>• Transport – samples and people<br>• Parking<br>• Technology<br>• Communications<br>• Security<br>• Catering<br>• Language Services<br>• Waste Management<br>• Procurement of specialised doping control equipment.<br>• Procurement of all equipment and consumables required |
| Administrator - Workforce | G- 24 | • Provide administrative support to the Coordinator - Workforce;<br>• Coordinate audio-visual, conference phones, room bookings, catering etc. for training sessions;<br>• Undertake special projects and activities for the Programme Manager as required. |

# 10.0 → Test Distribution Plan

## Executive Summary

**Introduction** This chapter describes the Test Distribution Plan.

**Contents** This chapter contains the following topics:

| Topic |
|---|
| 10.1 Overview |
| 10.2 IOC Requirements for Test Distribution Planning |
| 10.3 Statistics from Previous Games |
| 10.4 Factors for Consideration |
| 10.5 Test Distribution Plan Development Phases |

# 10.1 Overview

**Introduction**

This section describes the requirements for and issues related to the development of the Test Distribution Plan (TDP).

**Background**

While historically OCOGs have relied on previous Games and International Federation requests as the key determining factors for the TDP, there are now requirements outlined in the IOC Anti-Doping Rules (for each Games edition).

Test Distribution Planning is now more complex due to the range of testing that is available.

**Major Deliverables**

- Draft Test Distribution Plan
- Final Test Distribution Plan

**Key Interactions**

- IOC Medical Director
- IPC Medical & Scientific Director
- OCOG Competition Managers
- International Federations for each Sport
- WADA

**Reference Documents**

- Previous Games Test Plans
- OCOG Sports programme - detailed by day/session
- IOC Anti-Doping Rules
- International Standard for Testing
- WADA Test Distribution Guidelines
- WADA Independent Observer Reports – Sydney 2000, Salt Lake City 2002, Athens 2004

**Comment**

While it is important to consult with the International Federations about their preferred test numbers it is recommended not to lock into any specific test numbers with separate International Federations until the OCOG has a full understanding of all the factors involved in the Test Distribution Planning.

# 10.2 IOC Requirements for Test Distribution Plan

**Introduction**

This section outlines the IOC requirements for the Test Distribution Plan (TDP).

**References**

The following paragraphs describe the obligations contained in the Olympic Charter and Host City Contract with regard to the Testing programme.

**IF Involvement**

△ ✕ ⬚

The Olympic Charter provides for the IFs to propose the number of, and selection of, competitors for doping controls with this proposal requiring approval from the IOC Executive Board.

The IOC Anti-Doping Rules [for the Athens 2004 Olympic Games] states that "At the Olympic Games, the IOC in consultation with the ATHOC and the relevant International Federations shall determine the number of tests to be performed." The Rules outline the required number of doping controls for the post-competition Doping Control Programme. The selections are based on finishing position, random and target testing.

**IPC Anti-Doping Code**

▶ IPC

The Test Distribution Plan for the Paralympic Games is determined by the IPC Anti-Doping Subcommittee and the OCOG, with involvement and consultation with WADA, for any Out-of-competition testing components.

# 10.3 Statistics from Previous Games

**Introduction**

The following tables show the doping controls conducted at the previous two Summer Olympic and Paralympic Games.

**Note for Inconsistent Figures**

Note – The figures are offered as a guide only. It is possible that other statistics are available for these Games and although they appear different they are not necessarily inconsistent with the following figures. For example, the OCOG may count one test for one Athlete however, if two samples were collected from the same athlete due to a dilute first sample, the Laboratory may count that as two tests.

**Olympic Games**

| Type of Sample/ doping controls | Sydney 2000 | Athens 2004 |
|---|---|---|
| Urine –Out-of-Competition (OOC) | 404 | 543 (pre-competition) |
| Blood + urine – EPO | 307 | |
| Blood OOC | | 306 (pre-competition) |
| Blood in competition | | 385 |
| Urine in competition | 2052 | 2383 |
| | | |
| **TOTAL** | **2763** | **3617** |

**Note**: The Sydney blood collections were serum and whole blood for EPO testing. The Athens blood collections were serum and/or whole blood for one to three tests for Human Growth Hormone (hGH), Haemoglobin Based Oxygen Carriers (HBOCs) and Blood Transfusions.

Continued on next page

# 10.3 Statistics from Previous Games, Continued

**Paralympic Games**

| Type of Sample/ doping controls | Sydney 2000 | Athens 2004 |
|---|---|---|
| Urine –OOC | 128 | 165 |
| Blood – OOC | 0 | 0 |
| Urine – Competition | 520 | 515 |
| Blood – Competition | 0 | 0 |
| | | |
| **TOTAL** | **648** | **680** |

# 10.4 Factors for Consideration

**Introduction** The following table outlines the key factors that should be considered when developing a Test Distribution Plan for the Olympic Games and Paralympic Games.

| Factors | Comments |
|---|---|
| Number of sports/events | May be a subsequent increase/decrease of total test numbers if the Sport Programme changes. |
| Record verification | Identify which sports require a doping control to be done to verify a record: World, Olympic, Regional and/or National.<br>(Recommend that the OCOG sets up a system for the NOCs to pay for National records). |
| Detection time of prohibited substances | Will impact on whether to test out-of – competition (OOC) and/or post-competition. |
| Type of samples required by laboratories | Depending on what tests are available the OCOG may be expected to collect Urine, Blood and Breathe samples.<br>Re Blood - Serum and /or Whole blood may be required. |
| Athletes test history | Recommend an allocation for some target testing to be used if there is any concern about a specific athlete. |
| Nature of the sport | Potential for advantage to be gained by use of prohibited substances in a sport may be considered, particularly for OOC Testing. |
| Nature of Disability<br>▶ IPC | Potential for advantage to be gained by use of prohibited substances relating to the athlete's disability may be considered. |
| WADA Independent Observer Reports – Sydney and Athens | The WADA Independent Observer Reports have recommended an increase of testing on team sport athletes. |
| New advances in detection technology | During the planning time contingency must be considered for any new tests, which due to the impetus of the Olympic Games are often developed close to a Games. |

# 10.5 Test Distribution Plan Development

**Introduction**

This section describes the process involved in the development of the Test Distribution Plan.

**Major Deliverables**

- Draft Test Distribution Plan
- Final Test Distribution Plan

**Process**

The following table outlines the series of events needed to be undertaken to develop the Test Distribution Plan.

| Step | Action |
|---|---|
| 1 | Review previous Games Test Programmes. |
| 2 | Review current Games Sports Programme. |
| 3 | Consult with IOC Medical Director for preliminary directions. |
| 4 | Determine if Doping Control Agreements will be developed between the IOC, the OCOG and each IF (see comments below). |
| 5 | Review current Doping Control Programme strategies with regard to timing of sample collection (OOC/Competition) and type (urine/blood). |
| 6 | Discuss any limiting factors with WADA-Accredited Laboratory/potential Laboratories. |
| 7 | Develop draft Test Distribution Plan. |
| 8 | Discuss draft TDP with IOC Medical Director. |
| 9 | Discuss draft TDP with each International Federation (only specific sport). |
| 10 | Discuss any possible combined programme with WADA, with regard to the OOC/pre-competition phase. |
| 11 | Finalise TDP (acknowledging that some flexibility should be built in to the Plan) with IOC. |
| 12 | Finalise the Doping Control Agreements with each IF. |

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# 10.5 Test Distribution Plan Development, Continued

**Agreements with International Federations**

- IPC

Written agreements have been made between the IOC, the OCOG and each IF at all Games since Atlanta 1996. These agreements have only been for In-Competition testing.

**Advantages of Agreements:**

- All parties know and agree to the Programme;
- Subsequent planning for space and personnel is based on agreement;
- Athlete Selection methodology and timing can be agreed.

**Disadvantages of Agreements:**

- Test Plan becomes known to a number of people;
- Test Plan becomes locked in so it is not so unpredictable (a positive deterrence is unpredictability);
- Need to adapt with new test methods (e.g. OOC Testing, Blood testing).

Such Agreements have not previously been made for the Paralympic Games

# 11.0 → Doping Control Workforce

## Executive Summary

**Introduction**

This chapter describes what the Doping Control Programme will have to consider and address to ensure it has an appropriate workforce.

**Scope**

✕

It is acknowledged that the OCOG Games Workforce Division has the primary responsibility for the entire Games Workforce, and the detailed processes regarding the general steps of recruitment, training, rostering, etc., are covered in the Technical Manual on Workforce.

However, the Doping Control Programme has some specific challenges to ensure sufficient appropriate Doping Control personnel are recruited and trained, with the timing and processes being outside the scope and timing of the Workforce Division.

**Contents**

This chapter contains the following topics:

| Topic |
|---|
| 11.1 Type of Workforce |
| 11.2 Venue Doping Control Teams |
| 11.3 Training & Management |

# 11.1 Type of Workforce

**Introduction**

This section describes the type of Workforce the Doping Control Programme will need to recruit and manage.

**Key Interactions**

- OCOG Games Workforce Division
- National Anti-Doping Organisation (NADO) – if one exists
- International Anti-Doping community

**Reference Documents**

- International Standard for Testing
- Sample Collection Personnel: Recruitment, Training, Accreditation and Re-Accreditation Guidelines

# 11.1.1 Specialist Workforce

**Introduction**

This section describes the type of personnel that will be required by the Doping Control Programme and the issues and decisions that should be made about the personnel.

**Key Interactions**

- OCOG Games Workforce Division
- National Anti-Doping Organisation (NADO) – if one exists
- International Anti-Doping community

**Key Issues**

- The number of existing Doping Control personnel, particularly Doping Control Officers, in the Host City/Country
- The OCOG's ability to recruit experienced personnel/new trainees
- The number of Field Training opportunities for trainees

**International Standard for Testing**

▶ IPC

The International Standard for Testing, which as part of the World Anti-Doping Code and an obligation for the OCOG, outlines the requirements for the training and qualifications of the Doping Control personnel, including considerations for working with athletes with a disability.

**Specialist Workforce** – ✕

Due to the tasks to be undertaken by the Doping Control Programme, its personnel are regarded as part of the Games "Specialist" workforce, assuming they have an existing level of expertise rather than part of the "General" workforce requiring primarily general skills and only needing short-term Function training and general Games time training. See Technical Manual on Workforce for details about the types of personnel.

This is of particular relevance to the positions of Doping Control Venue Manager, Doping Control Officer (DCO) and Chaperone Coordinator, however all positions are regarded as Specialist Workforce.

**National Anti-Doping Organisation (NADO)**

If a NADO exists in the Host Country then this organisation can play a key role in providing access to experienced Doping Control personnel.

The Games programme will also leave the NADO with the valuable legacy of an increased pool of trained, experienced anti-doing personnel.

Continued on next page

# 11.1.1 Specialist Workforce, Continued

**Limited Existing Specialists**

There are particular challenges relating to building the Doping Control Workforce as it is most probable that, even if there is an established NADO, a Host City does not have sufficient experienced "Specialist" Doping Control personnel to conduct the Doping Control Programme.

Thus, recruitment of inexperienced people requiring significant workshop and field training should commence with sufficient time to gain the necessary experience, and thus be regarded as "Specialists".

**International Recruitment Option**

Alternatively, or in combination, experienced Doping Control Officers could be recruited from other countries, with the subsequent costs/issues relating to their services, provision of accommodation and other support required, but with the need for significant amount of training diminished.

**Volunteers/ Contractors**

Volunteers - both nationals and internationals - have traditionally filled most if not all field operational positions, however, an OGOC should determine whether sufficient volunteers can be recruited nationally or from overseas, or alternatively plan for some or all positions to be paid positions.

**Field Training Opportunities**

The number of Field Training opportunities to ensure Doping Control personnel is appropriately prepared for the Games will need to be assessed before an OCOG can determine how many inexperienced people can be recruited and trained in time for the Games.

Field Training should include "real" doping control sessions, not just simulated sessions.

Continued on next page

# 11.1.1 Specialist Workforce, Continued

**Summary** The following table summarises the issues and options outlined above

| Issue | Implications/Comments |
|---|---|
| Doping Control Specialist Workforce | • Expectation of expertise |
| Limited existing national specialists | • Recruit all available Specialists<br>• Provide travel and accommodation for workforce not living in Host City for Test Events and Games time |
| Recruit nationally – within Host City | • Significant training required<br>• No travel or accommodation costs for training or Games time<br>• There may be limited field training opportunities in one city<br>(See 3.3 Training for detail) |
| Recruit nationally – outside Host City | • Significant training required<br>• May be travel and accommodation costs for training, Test Events and Games time<br>• Geographically spread group will provide broader access to field training opportunities<br>(See 3.3 Training for detail) |
| Recruit International "Specialists" | • Will be travel and accommodation costs for Games time and possibly Test Events<br>• Will only require Final Workshop to ensure consistency (See 3.3 Training for detail)<br>• Will provide significant expertise |
| Recruitment conditions:<br>Volunteer, Paid or mix of these options | • Historically Doping Control has primarily used Volunteers, although Salt Lake City and Athens did pay/contract a small number of positions.<br>• Need to determine best option considering the "volunteerism culture" within Host City/country.<br>• Many international DCOs are keen to be involved and prepared to participate on a voluntary basis if travel, accommodation and honorarium provided. |

# 11.1.2 Statistics from Previous Games

**Introduction**

This section provides information about the number of Doping Control personnel used in previous Games to implement the Doping Control Programme in the Venues.

**Workforce from Previous Summer Games**

The following tables outline the number of Doping Control volunteers/contractors used at the Sydney 2000 and Athens 2004 Games, and issues relating to their recruitment.

| Olympic Games | Number | Comments |
|---|---|---|
| Sydney 2000 | 410 | All Volunteers, primarily Australian but a number of experienced international DCOs.<br>Includes small number working as Sample Escorts/Couriers and in Command Centre. |
| Salt Lake City 2002 | 300 | 30 Paid staff in Venues<br>270 Volunteers |
| Athens 2004 | 560 | Primarily Greek Volunteers, with a small number of international DCOs and chaperones, including some without previous experience or training (not recommended).<br>Includes approximately 40 paid contractors for the Olympic Games in the positions of DC Venue Managers and Head Medical Officers (DCOs). |

| Paralympic Games | Number | Comments |
|---|---|---|
| Sydney 2000 | 135 | All Volunteers, primarily Australian. |
| Salt Lake City 2002 | 105 | 30 Paid staff<br>75 Volunteers |
| Athens 2004 | Approx. 90 | Primarily Greek Volunteers.<br>Includes approximately 20 paid contractors for the Paralympic Games in the positions of DC Venue Managers and Head Medical Officers (DCOs). |

**Salt Lake City Games**

Although the statistics are somewhat irrelevant for a Summer Games Doping Control Programme (as there is a significantly different number of doping controls conducted) the Salt Lake City Games are also included to illustrate the basis of recruitment of their workforce.

# 11.1.3 Other Positions Required

**Introduction**

This section outlines the Doping Control Programme positions that may be required other than in the Venue Doping Control Stations (covered in 3.2).

**Additional Positions**

The following table outlines the additional positions that may be required by the Doping Control Programme.

| Position | Role | Comment |
|---|---|---|
| Doping Control Command Centre Assistants | Assist in all operations of Doping Control Programme | Large workload with workforce management. |
| IOC/IPC Doping Control operations Assistants | Assist IOC/IPC in all Doping Control operations | Provide support to IOC/IPC regarding Therapeutic Use Exemptions administration and general operations. |
| Doping Control Accommodation [Centre] Assistant | Assist Doping Control workforce with accommodation issues, and at their accommodation centre (if one exists) | Most likely that there will be a significant number of the Doping Control workforce from outside of the Host City, so having someone allocated to assist with accommodation issues will greatly enhance the smooth operations of the Doping Control Programme. |
| Courier Chaperone | Accompany samples from Venue to Laboratory | Can have this Chaperone travel with Courier Car/company.<br>See 5.2 Transport of Samples for further detail. |
| WADA Assistants | General assistance to WADA:<br>• Independent Observer Programme;<br>• Athlete Outreach Programme in Village; and<br>• Executive Office | See 7.0 WADA requirements.<br>In the spirit of cooperation in the Doping Control movement the Doping Control Programme should assist in facilitating the WADA Requirements. |

# 11.2 Venue Doping Control Teams

**Introduction**

This section describes the recommended make-up and profile of the Doping Control team at the Venues and outlines the process for determining how many people are required.

This section contains the following topics:

- Venue Team structure
- Profiles of Each Position
- Process for Determining Required Number of Staff

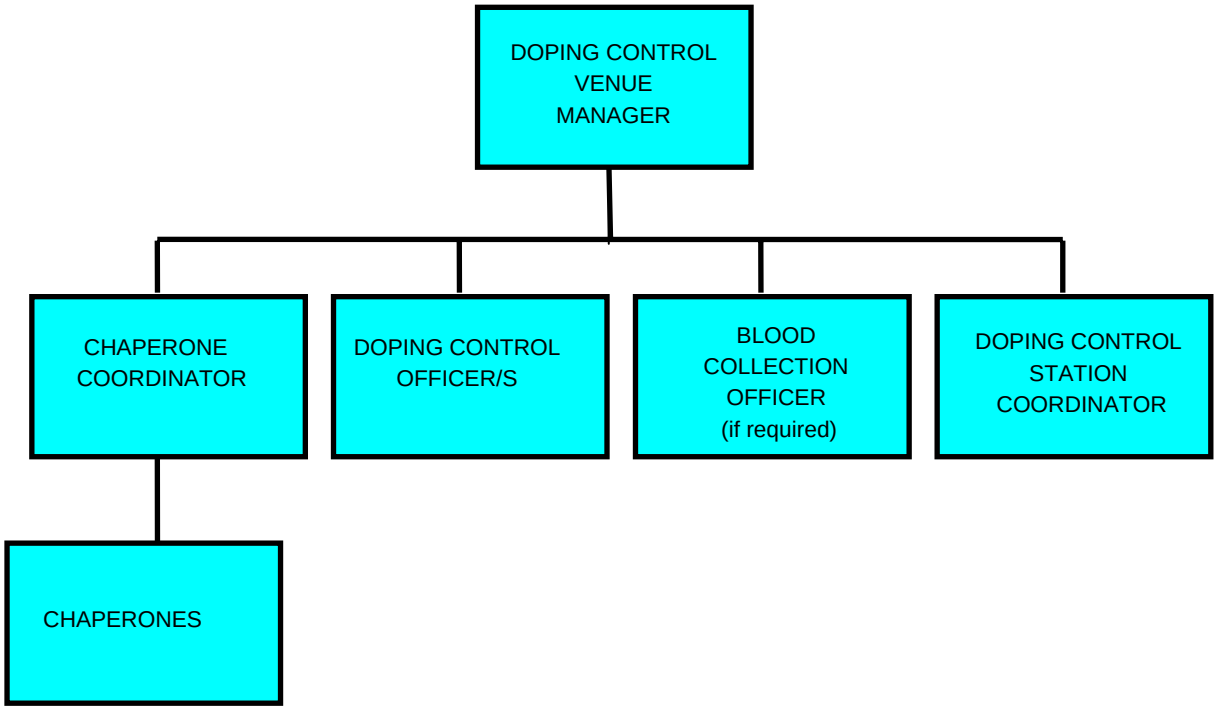
# 11.2.1 Venue Team Structure

**Introduction**

This section provides a recommended structure for Doping Control at a Competition Venue.

**Venue Team Structure**

The following diagram illustrates the recommended Doping Control Competition Venue team structure:




**Reference**

The recommendation is a new structure based on the venue team structures used in Sydney 2000 and Athens 2004.

**Village Polyclinic Doping Control Team**

The Doping Control Team required for the Village Polyclinic should be based on the same structure as outlined above.

# 11.2.2 Profiles of Each Position

**Introduction**

This section provides information on the profile and key role of each doping control position.

**Venue Doping Control Team Structure**

The following table describes the role and number of each of the positions in the Venue Doping Control team.

| Position | Role | Number | Profile/Comment |
|---|---|---|---|
| **Doping Control Venue Manager**<br>Alternative title:<br>Doping Control Venue Leader | • Manage Doping Control process at the allocated Venue.<br>• Manage Doping Control staff at the Venue. | May have 2 DCVMs or a "deputy" allocated if there is a long daily programme over a long period of the Games. | • Very experienced Doping Control Officer<br>• Strong management skills.<br>• Good understanding of the whole doping control process and Doping Control rules to implement them correctly but also to know when it is possible to flexible. |
| **Doping Control Station Coordinator** | • Manage the set up and maintenance of the Station.<br>• Ensure all aspects of the site runs smoothly<br>• During the testing session be responsible for the Check-in/out of athlete. | May have 2 DCVMs or a "deputy" allocated if there is a long daily programme over a long period. | • Very good organiser.<br>• Should live in Host city to enable involvement in lead up preparations.<br>• Recommend becoming part of the Venue planning team at least one month before the Games. |
| **Doping Control Officer** | • Witness the provision of the urine sample by the Athlete.<br>• Conduct the sample sealing process with the Athlete. | 1-2 DCOs for each Urine Processing Room and 1 per each Blood Processing Room within the Station.<br>Gender specific due to role. | • Skills to be able to follow directions and implement the sample collection process accurately and efficiently.<br>• DCOs to work in pairs within one processing room of a Doping Control Station - mixed gender or same gender depending on sport. |

Continued on next page

# 11.2.2 Profiles of Each Position, Continued

**Venue Doping Control Team Structure** (continued)

| Position | Role | Number | Profile/Comment |
|---|---|---|---|
| **Blood Collection Officer/ Phlebotomist** (if blood samples collected at the venue) | • Blood sample collection from Athlete;<br>• Prepare and centrifuge the sample, if required. | 1 for each Blood Processing Room | • Qualified and experienced phlebotomist regardless of whether a medical doctor.<br>• Not necessary to be a DCO but needs understanding of sealing procedures. |
| **Chaperone Coordinator** | • Manage Chaperones at the Venue.<br>• Assist Chaperone in notification process. | Normally 1 per Venue but may require additional if multi-arena venue or complex programme (e.g. Athletics) | • An experienced Chaperone.<br>• Good organiser and manager of people.<br>• Ideally knows the allocated sport/s very well. |
| **Chaperone** | • Notify selected athlete<br>• Accompany athlete until he/she reports into the Doping Control Station<br>• Assist in supervision of Athletes in Waiting Room | Generally 1 for each athlete to be tested unless significant time between notifications. Gender specific due to role. | • Good communicator.<br>• Can follow processes/directions from Chaperone Coordinator. |

**Additional Comment**

It is the practice for some NADOs/countries to use Medical Doctors as DCOs , however, this is not required by the World Anti-Doping Code International Standard for Testing.

**Venue References**

For more detailed information on the Doping Control Station and spaces within the Station mentioned in this chapter see Chapter 4 Venue Requirements.

# 11.2.3 Process for Determining Required Number of Staff

**Introduction**

This section describes the process for determining how many people the OCOG should appoint in each identified position in each Venue Doping Control Team.

**Summary**

The number of people required in each position and in each Venue is dependent on the Test Distribution Plan and more specifically, the number of doping controls to be conducted over a given period of time.

**Issues to Consider**

The following table outlines the issues to be considered when determining the number of people required.

| Issue | Comment |
|---|---|
| Unknown timing of Urine provision | Timing varies due to:<br>• the biological aspect of the Athlete being dehydrated, particularly after exercise<br>• the psychological nature of being witnessed providing the sample |
| Gender specific tasks | The DCO witnessing the provision of the urine must be same gender as the Athlete.<br>It is preferable for the Chaperone to also be the same gender as the Athlete to enable access to change rooms |
| Combined roles if small number of doping controls to be conducted in the testing session | The structure outlined in 3.2.1 is a general structure.<br>A number of the responsibilities of the described positions can be completed by one person, for example:<br>• the DC Venue Manager act as the Chaperone Coordinator;<br>• The Chaperone Coordinator act as a Chaperone. |
| Drop out | • As the recruitment process must commence a significant period of time before the Games and as there is a significant workload involved in the training process, the OCOG should allow for 10% drop out rate. |
| Out-of-Competition Notifications | It is very resource intensive trying to locate and notify Athletes for the Out-of-Competition Testing programme so the OCOG needs to provide enough resources for whatever the number of planned tests are. |

Continued on next page

# 11.2.3 Process for Determining Required Number of Staff, Continued

**Process**

The following table outlines the series of stages to determine the number in each position in the Venue Doping Control Team

| Stage | Description |
|---|---|
| 1 | Using the draft Test Distribution Plan and the peak number of doping controls for each Venue identify the number of Processing Rooms required within each Venue Doping Control Station.<br>(See 4.0 Space and Venue Requirements for details on this process) |
| 2 | Identify which Venues will require their own Doping Control team for the duration of the Games. |
| 3 | Identify which Venues can share a Doping Control Team with one or more other Venues. |
| 4 | Identify which Venues require significant gender variations on different days or different parts of the day. |
| 5 | Identify which Venues require a significant change of workforce during Games (e.g. Rowing - small number of random tests on 5-7 days, large number of Finals tests on 2 days) |
| 6 | Estimate the Workforce based on the outcome of stages 1-5 |
| 7 | Recruit and commence required training of the estimated workforce |
| 8 | Review and revise if any alterations to sports programme. |
| 9 | Review and revise workforce numbers once Test Distribution Plan is finalised. |
| 10 | Repeat the process for the Paralympic Games. |

# 11.3 Training & Management

**Introduction**

This section outlines the requirements and issues relating to the training and rostering of Doping Control personnel.

**Overview**

Appropriately trained and qualified Doping Control personnel are a vital element of an effective Games Doping Control Programme. If Doping Control processes are not implemented in accordance with the International Standards and other relevant Doping Control rules, there is a possibility that an athlete may successfully challenge a Doping Control rule violation.

It is important that the appropriate number of personnel are rostered to accommodate the timing uncertainties related to the nature of the Doping Control process.

**Key Interactions**

- OCOG Games Workforce Division – Training section
- National Anti-Doping Organisation (NADO) – if one exists

**Reference Documents**

- International Standard for Testing
- Sample Collection Personnel: Recruitment, Training, Accreditation and Re-Accreditation Guidelines

# 11.3.1 Workshop & Field Training

**Introduction**

This section outlines the requirements and recommendations for training of Doping Control personnel.

**Training Plan**

Once the OCOG's recruitment strategies are determined, and recruitment has commenced there should be an analysis of the training needs of the personnel recruited or expected to be recruited and a training plan developed.

The Training Plan should include:

- Workshop and field training programmes for each Doping Control position
- The number and timing of workshop and field training sessions required for each position
- Field opportunities – simulated and real sessions, including the Test Events

Determining when Training should commence will depend on the profile of the people recruited, for example, how many new recruits with no background in Doping Control are to be trained; how many existing Doping Control Officers have been recruited, etc

**Reference Documents**

- International Standard for Testing – Annex G – Sample Collection Personnel Requirements
- WADA is developing more detailed Model Guidelines for the recruitment and training of Personnel. These Guidelines which are expected to be completed in 2005 are recommended to be used as a reference document:

"Sample Collection Personnel: Recruitment, Training, Accreditation and Re-Accreditation Guidelines"

**Training Resources**

Videos outlining the detailed doping control processes have successfully been used by previous OCOGs for training purposes. It is important that the video is carefully scripted if it is to be used in training.

Detailed Operational Manuals should also be developed to ensure the consistency of procedures for all personnel.

Continued on next page

# 11.3.1 Workshop & Field Training, Continued

**Workshop Training Programmes**

Separate workshops programmes and/or sessions should be organised to accommodate the training needs of the different positions and personnel, for example: the Doping Control Officers will require more training sessions than the Chaperones; the new recruits will require more training than the experienced personnel.

It is recommended that five workshop training programmes be developed, which should include simulated doping control processes. The programmes are:

| Course | Type |
|---|---|
| **A** | DC Venue Managers (DCVM |
| **B** | Doping Control Officers (DCO) |
| **C** | DC Station Coordinators (DCSC) |
| **D** | Chaperone Coordinators (CC) |
| **E** | Chaperones |

**Final Workshop**

It is recommended that a final workshop be held involving the entire Doping Control workforce to ensure that all personnel are aware of and understand all policies and procedures, particularly any fine-tuning determined over the progress of the lead up period.

To enable all personnel from overseas or other cities to be involved this Workshop will need to held as close as possible to the Opening Ceremony, acknowledging that a group of the Workforce will already be involved with the delivery of the Out-of-Competition Testing Programme.

Continued on next page

# 11.3.1 Workshop & Field Training, Continued

**Field Training Programme**

Field training should be interspersed with the workshop training sessions and where possible closely follow workshop training to maximise the learning environment.

### Real Doping Control Processes

While simulated doping control processes should initially be used in a field setting, trainees should also experience real doping control processes. However, it is acknowledged that there are limited opportunities for "real" training as doping control is such an intrusive process and should be part of a legitimate Doping Control Programme.

Any "real" doping control processing should be conducted in accordance with the International Standard for Testing and any other relevant Doping Control rules so experienced personnel should supervise and take responsibility for any real doping control process being used for training.

### Use of National Programmes for Experience

It is recommended that the OCOG negotiate with any existing NADO or any other Doping Control Organisation in the country and/or region (where appropriate) to be able to conduct, or at least be involved with, any Doping Control Programmes being conducted in the Host Country in the lead up to the Games so the trainees can get this invaluable field experience.

**Test Events**

It is recommended that the Doping Control Programme be involved in every Test Event to utilise the "real" training opportunity provided, as well as for the other operational benefits relating to testing and evaluating the doping control processes and working with other Functions.

### Doping Control Rules

Test Events should be conducted under the relevant Doping Control rules for the event, which would be either the International Federation Doping Control rules, or the National Doping Control rules depending on the event/sport.

# 11.3.2 Rostering of Field Personnel

**Introduction**

This section describes the issues involved with the efficient and effective management of the rostering of field personnel.

**Scheduling of Personnel**

Doping Control personnel will be rostered to one or more Venues from the Opening of the Village to the completion of the Games programme.

### Workforce Division Understanding of Issues

It is important to gain the understanding of the Workforce Function and later the Venue team management that Venue Doping Control personnel numbers and actual people will vary throughout the Games programme depending on the Test Distribution Plan, with the variance primarily linked to the Sports Programme.

**Infinity Accreditation**

It is recommended that the Doping Control Workforce be given Infinity Accreditation to support the flexible requirements of the testing programme.

Continued on next page

# 11.3.2 Rostering of Field Personnel, Continued

**Workforce Variance at Venues**

The following table outlines the factors that impact on the variance in numbers of personnel and actual personnel.

| Factor | Test Distribution Plan | Impact on Doping Control Programme | Rostering considerations |
|---|---|---|---|
| Sports Programme: Preliminaries, Finals | Small number of tests increasing to larger number of tests<br>Examples :<br>Beach Volleyball – Prelim. -2, Finals - 8<br>Rowing –<br>Prelim.-10; Finals - 28 | • Increase in Processing Rooms and Doping Control Officers required.<br>• Increase in number of Chaperones required. | Significant increase of Doping Control team size from preliminaries to Finals e.g. :<br>Beach VB - 5 to 14<br>Rowing – 16 - 40 |
| Sports Programme:<br>Men's and Women's competitions alternating between days or between sessions within a day | Testing of Men on one day; testing of Women the following day with this pattern being repeated throughout Games. | Gender specific tasks-<br>• Chaperone accompanying the Athlete<br>• DCO witnessing the provision of urine | Change of large number of the team on alternate days or change between the morning and evening sports sessions. |
| Uncertain length of time of Doping Control process | N/A | Due to physiological and psychological factors relating to the Athlete providing a witnessed urine sample, it is not possible to schedule finish times for personnel, particularly for the DCOs. | Try to avoid rostering a DCO for an evening session followed by an early morning session. |

# 12.0 → Venue Requirements

## Executive Summary

**Introduction** This chapter outlines the venue requirements of the Doping Control Programme.

**Contents** This chapter contains the following topics:

| Topic |
|---|
| 12.1 Doping Control Stations |
| 12.2 Other Required Spaces - Competition Venue |
| 12.3 Non-competition Venues |

# 12.1 Doping Control Stations

**Introduction**

This section describes and illustrates the elements and size variances of a Doping Control Station and the services required within the Station.

**One Station per Venue**

It is recommended that each Competition Venue have its own Doping Control Station.

**References**

- International Standard for Testing
- IOC Anti-Doping Rules
- IPC Anti-Doping Code

**Criteria for Doping Control Station**

The general criteria for a Doping Control Station are set out in the International Standard for Testing, which as part of the World Anti-Doping Code is an obligation for the OCOG.

Further detailed criteria of a Station as required by the IOC are included in the IOC Anti-Doping Rules.

# 12.1.1 Location within Venue

**Introduction**

This section describes the recommended location of the Doping Control Station within the Venue

**Location**

The Doping Control Station should be located
- in the "Back of House" area of the Venue;
- preferably in the Athlete area; and
- where possible close to the Mixed Zone.

**Reference**

A diagram illustrating the back of house spaces is in the Technical Manual on Venues - Design Standards for Competition Venues.

**Permanent vs. Temporary Stations**

It is recommended that a needs analysis of a Venue/sport be conducted to determine whether a long term Doping Control Station would be of value to the Venue/sport; whether a temporary Station is suitable or a combination - i.e. A larger temporary Station to accommodate the Games Doping Control Programme which is able to be reduced in size for the permanent Station.

# 12.1.2 Elements within Doping Control Station

**Introduction**

This section describes and illustrates the spaces within a Doping Control Station.

**Elements of Each Station**

A Doping Control Station consists of the following spaces:

| Name | Description |
|---|---|
| Reception | • Desk for controlling entry and exit to the Station.<br>• Athletes and accompanying people (representative, language services) are signed in and out at the Reception desk. |
| Waiting Area | • Area where the selected Athlete re-hydrates under supervision until ready to provide a sample;<br>• Includes TV to help Athlete to relax. |
| Urine Processing Room<br>(one or more) | Room where:<br>• the Athlete reports to when ready to provide a sample;<br>• where the sample is sealed;<br>• preliminary tests are done;<br>• documents are completed; and<br>• sealed sample is stored in a locked fridge until the completion of the session. |
| Toilet<br>(one or more) | • Where the Athlete urinates under direct observation of a same gender Doping Control Officer, therefore should accommodate two (2) people.<br>• A "Disabled toilet facility" is the recommended size. |
| Blood Processing Room<br>(one or more) | Room where:<br>• the Athlete reports to when ready to provide a sample;<br>• where the sample is provided and sealed;<br>• documents are completed; and<br>• the sealed sample is stored in a locked fridge until the completion of the session.<br>• If required, it is where the samples are centrifuged. |
| Office/Storage<br>(for larger Stations) | Area where:<br>• sample collection equipment and forms are stored securely;<br>• where athlete doping control operations are run; and<br>• from where the courier will pick up the samples to take to the laboratory.<br>If there is no Office then these functions are incorporated in the existing spaces. |

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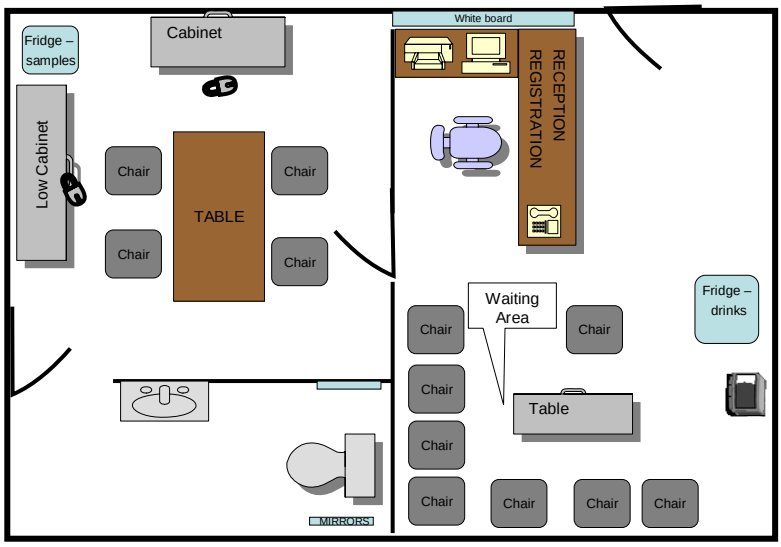
# 12.1.2 Elements within Doping Control Station, Continued

**Diagram of a Station**

The following is a diagram of a Doping Control Station

Doping Control Station: Basic Design




**Paralympic Requirements**

If the venue is to be used for the Paralympics, the Station should be able to accommodate athletes in a wheelchair.

- IPC

# 12.1.3 Size of Doping Control Stations

**Introduction** This section describes how to determine the size of each Venue's Doping Control Station

**Size of Station** The size of the Station, particularly the Waiting Area and the number of Processing Rooms and Toilets will depend on the Test Distribution Plan and the peak number of doping controls to be conducted in a period of time, for example in an hour.

### Recommended Basis

It is recommended that the initial base number should be for a maximum of four (4) Athletes to be notified in an hour for the basic "D" size Station, on the basis of one doping control process taking 15 minutes to complete.

**Examples** The following table provides a profile of different size Stations

| Size | Peak no. of tests in one hour | Reception | Waiting Area | Urine Processing Room/s | Toilet/s | Blood Processing Room/s | Office/ storage |
|---|---|---|---|---|---|---|---|
| A* | 19-30 | 1 | X-Large | 4-5 | 4-5 | 1-2 | 1 |
| B | 11-18 | 1 | Large | 3 | 3 | 1 | 1 |
| C | 5-10 | 1 | Medium | 2 | 2 | 0 | 0 |
| D | 1-4 | 1 | Small | 1 | 1 | 0 | 0 |

**A* Stations** A Stations need to be custom built as there will be a range of size and requirements at this size. For example it is recommended for the Athletics Venue that an additional Doping Control Station or section within the existing Station be set up to accommodate the tests required to verify National Records.

# 12.1.4 Services Required within Station/Venue

**Introduction** This section describes the services required within the Station and Venue.

**Services Required Within Venue/Station** The following table outlines the services that will be required from the various Functions:

| Function | Services required |
|---|---|
| Catering | • Sealed drinks, portable drink carriers.<br>• Drinks fridges (or may be provided by Venues). |
| Communication/ Technology | • Radios for communication between the Station, the DC Venue Manager, the Chaperone Coordinator and the Chaperones<br>• Must have own radio line for secure communication<br>• Hard phones, fax machine<br>• TVs within each Station.<br>Computers, if required but not recommended as necessary |
| Language Services | • Language assistance for the Notification and Sample sealing processes |
| Security | • Security outside each Doping Control Station controlling access |
| Sport | • Provision of Start and Result Information to assist in Notification process<br>• Access to Field of Play for monitoring competition and Notification processes |
| Transport | • The OCOG is required to consider the timing of doping control and ensure the provision of transport services until the end of the doping control process for athletes, team officials, workforce and other impacted clients |
| Venues | • Provision of all furniture, fit-out and equipment |
| Waste Management | • Hazardous waste bins, Recycling bins |

# 12.2 Other Required Spaces - Competition Venue

**Introduction**

This section describes the spaces other than the Doping Control Station required by Doping Control within each Competition Venue.

**Spaces Required**

The following table outlines the spaces required.

| Space | Requirement | Location |
|---|---|---|
| Field of Play Table:<br>Relevant for most but not all Sports | Table at which to monitor progress of competition and make the Athlete Selections with the IF Doping Control Representative. | On or close to "Field of Play" (FOP) depending on sport.<br>Should have easy access to the Athlete as they finish competition. |
| Parking space for Courier:<br>Essential for all Venues | Parking space for the Courier responsible for transporting the collected samples from the Venue to the Laboratory. | Should be as close as possible to the Doping Control Station to maintain the secure Chain of Custody of the sample |
| Parking space for Doping Control Venue Manager:<br>Preferable for all Venues | Access to Parking space at the Venue to support the DC Venue Manager who is often at the Venue for long hours. | Not necessarily close to the Station but within the Venue parking area. |
| Chaperone Waiting Room:<br>Preferable at venues with "A" size Doping Control Stations | There is usually not enough space in the DC Station Waiting Room to accommodate large number of Chaperones, so for the large programmes a separate room/space is preferable | As close as possible to either the Mixed Zone or the Doping Control Station for ease of management of the Chaperones. |

# 12.3 Non-Competition Venues

**Introduction**

This section describes the spaces required in non-competition Venues.

**Doping Control Command Centre**

The Doping Control Programme will require a Games-time Command Centre. The Command Centre must be fully secure due to the sensitivity of the doping control plans, documents and operations. All of the OCOG's Doping Control operations will be run from this Command Centre.

**Village Doping Control Station**

Doping Control will require a Doping Control Station to be established within the Village. Previous OCOGs have located this Station within the Village Polyclinic, which is suitable but not essential. This Doping Control Station should be used for:

- Out-of-competition testing conducted prior to an Athlete's competition starting;
- Late night testing when an Athlete has not been able to complete the doping control process and is transferred to the Village Doping Control Station;
- Other testing as required.

The Station should be of an A size (see 4.1.3).

**Training Venues**

It is possible that a Doping Control Station will be required at designated Training Venues to assist with the delivery of the Out-of-Competition Testing Programme. This need will depend on the sport and the location of the Training Venue.

**Laboratory**

It is recommended that the Laboratory be regarded as a Non-Competition venue to ensure it is provided with appropriate Games Security and any signage requirements.

# 13.0 → Testing Process

## Executive Summary

**Introduction**

This chapter describes the sample collection, sample handling and sample transport parts of the Testing process.

**Overview**

### Chain of Custody

A secure "Chain of Custody" of the Athlete and the samples is required to preserve the confidentiality of the proceedings and to ensure that there is no opportunity for tampering or substitution of the samples.

### Results Management

The IOC and the IPC are responsible for the management of results for the Olympic Games and Paralympic Games respectively.

The OCOG may be asked to provide support for the Result Management process however, it is not responsible for the management of the results, including the Hearing processes.

**Contents**

This chapter contains the following topics:


| Topic |
|---|
| 13.1 Sample Collection & Handling Processes |
| 13.2 Transport of Samples & Documentation |
| 13.3 Informing NOCs/Athletes of Testing Process |

# 13.1 Sample Collection & Handling Processes

**Introduction**

This section describes the Sample Collection and Sample Handling Processes.

**Consistency with WADA Code**

▶ IPC

As the IOC and the IPC are signatories of the World Anti-Doping Code, the IOC and IPC require that the OCOG's Sample Collection procedures are consistent with the Code's International Standard for Testing.

**References**

There are a number of key reference documents relating to this obligation:

**International Standard for Testing**

The principles of the Sample Collection and Handling processes are outlined in the World Anti-Doping Code's International Standard for Testing and associated Guidelines.

This document provides all the principles and standards relating to the doping control process and in particular the Testing parts of the process. The Guidelines, in particular the Urine Collection and Blood Collection Guidelines, which are not mandatory but are useful, provide further detail.

**IOC Anti-Doping Rules**

The IOC Anti-Doping Rules, written in accordance with the World Anti-Doping Code, specify the requirement for an OCOG's doping control procedures to be in conformity with the International Standard for Testing.

**IPC Anti-Doping Code**

▶ IPC

The IPC Anti-Doping Code, written in accordance with the World Anti-Doping Code specifies that Testing shall be in substantial conformity with the International Standard for Testing.

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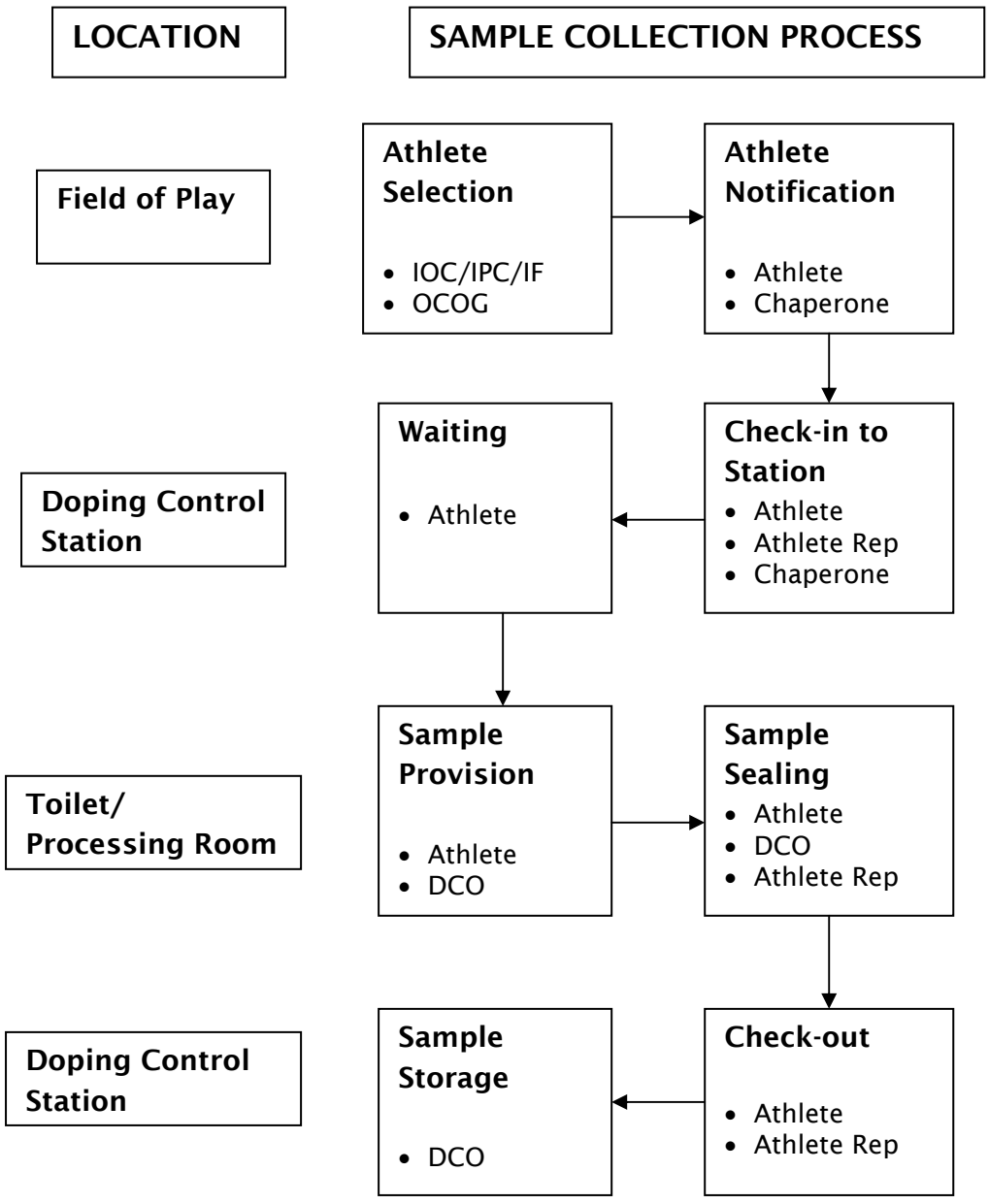
# 13.1 Sample Collection & Handling Processes, Continued

**Introduction** The following flow-chart illustrates the parts of the doping control process from the Athlete Selection stage until the collected sample is sealed and stored

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# 13.1 Sample Collection & Handling Processes, Continued

**Testing Process**

The following table provides a basic summary outline of parts of the Testing process from the Athlete Selection stage until the collected Sample is sealed and stored.

| Stage | Description |
|---|---|
| Athlete Selection | Athlete selection is made by IOC, IPC, IF and OCOG representatives in the manner and at the time and location agreed by all parties. |
| Notification | The Athlete is notified of his/her selection for a doping control immediately post-competition, or at an appropriate time if an out-of-competition test.<br>The Athlete is accompanied by a Doping Control Chaperone from this moment. |
| Check-in to Station | The Athlete checks in to the Doping Control Station. The Athlete has the right/option to be accompanied by an Athlete representative (e.g. manager, coach, doctor).<br>Access to the stations will be restricted, with security guards ensuring that only accredited staff, officials and selected Athletes (and their representatives) can enter. |
| Waiting | The Athlete re-hydrates until ready to provide a urine sample and/or is ready to provide a blood sample, if required.<br>Sealed drinks are provided to assist the Athlete. |
| Sample Provision | The Athlete provides a Urine sample under the direct observation of a same gender Doping Control Officer and/or the Athlete provides a blood sample. |
| Sample Sealing | Under direction from a Doping Control Officer, the Athlete seals the sample and completes the required documentation. |
| Check-out | The Athlete and representative check out of Station. |
| Sample Storage | The Sample is stored securely until the completion of the sample collection session. Unless otherwise agreed the IOC requires a lockable refrigerator for this storage. |

**Sample Collection Equipment**

▶ IPC

The Sample Collection Equipment to be used must meet the criteria outlined in the International Standard for Testing and be approved by the IOC.

For the Paralympics the Standard also requires the OCOG to ensure that the DCO has any information and the Sample Collection equipment necessary to conduct a Testing session with an athlete with a disability.

Continued on next page

# 13.1 Sample Collection & Handling Processes, Continued

**Sample Collection Documentation**

The Sample Collection documentation to be used should meet the criteria outlined in the International Standard for Testing and be approved by the IOC and IPC respectively.

▸ IPC

**Doping Control Operational Manuals**

It is important that the detailed processes are determined and documented within an Operational Manual to be provided to all Doping Control staff.

This is particularly important if international DCOs are used, as while international procedures are expected to be consistent with the International Standard there may be some variance in interpretation and practice.

# 13.2 Transport of Samples & Documentation

**Introduction**

This section outlines the requirements for the secure transport of the samples from the Venues to the Laboratory and the documentation to the relevant parties.

**International Standard for Testing**

The principles of the transport process are outlined in the World Anti-Doping Code's International Standard for Testing and associated Guidelines. The key principles are outlined in the following paragraphs:

### Secure Transport

The OCOG is responsible for planning a transport system that ensures samples and documentation will be transported in a manner that protects their integrity, identity and security.

### Chain of Custody

The OCOG is responsible for developing a system for documenting the Chain of Custody of the samples, which includes confirming that both the Samples and Sample documentation have arrived at their intended destinations.

### Courier Options

The transport of the Samples may be carried out by a commercial Courier company (the Athens system) or by developing an internal courier system (the Sydney system) using a member of the Doping Control Workforce (e.g. A Chaperone) to accompany a Courier Driver. More information can be found in the Technical Manual on Transport.

It is recommended to have two people accompanying the samples to the Laboratory.

# 13.3 Informing NOCs/Athletes of Testing Processes

**Introduction**

This section outlines the ways that the OCOG can inform the NOCs and through them, the Athletes about the Testing processes to be used at the specific Games.

**Limitation**

The information provided by the OCOG should primarily be about the Testing parts of the process, not the broader doping control processes of result management, hearings etc

**Technical Doping Control Procedures: Olympics Paralympics**

△ ⊏⊐ ▸ IPC

The OCOG shall prepare technical doping control procedures, approved by the IOC and IPC respectively, which will address the technical operations of the Doping Control Programme at the Games. This document will be added to the IOC Anti-Doping Rules prepared and distributed by the IOC.

Note – the obligation in the Olympic Charter is for a medical brochure, which previously included reference to the Doping Control Programme. However it has been the practice of previous OCOGs to write a separate technical doping control procedures.

After some critical observations from the WADA Independent Observer Team in Athens, it is important that the legal status of the Guide be clarified, however, it is a valuable information tool for the NOCs and NPCs.

**Doping Control Video**

If the OCOG decides to prepare a video for training purposes (used successfully in Sydney 2000) it is also recommended that the video be sent to all NOCs and NPCs for the information of the athletes and their support personnel.

**Information Session for Team Doctors and Manager**

▸ IPC

It is recommended to include information about the Doping Control Programme in the meeting of the IOC Medical Commission with the NOC team doctors usually held in the Village prior to the Opening Ceremony.

As Out-of-Competition Testing commences as soon as the Village is opened it is recommended that this meeting be held as soon as possible after the Opening of the Village. This information session should be repeated for the NPC Team doctors.

# 14.0 → Laboratory Requirements

## Executive Summary

**Introduction**

This chapter outlines the requirements and issues relating to the Laboratory used for the analysis of the Sample during the Games.

**WADA-accredited laboratory** △

The Laboratory used by the OCOG must be accredited by WADA.

**Contents**

This chapter contains the following topics:


| Topic |
| --- |
| 14.1 Accreditation & Location |
| 14.2 Service Agreement & Operations |

# 14.1 Accreditation & Location

**Introduction**

This section outlines the requirements for the Accreditation and location of the Laboratory to be used for the Games.

**Location of Laboratory**

△ ✕

As referenced in the Host City Contract, the duly accredited Laboratory, used upon the occasion of the Games, shall be situated in (or close proximity to) the city.

The IOC must approve the location of the Laboratory.

**Requirements & References**

The following references outline the requirements in relation to the Laboratory to be used for the Games:

**World Anti-Doping Code**

△ ⬚

The World Anti-Doping Code requires that samples by analysed only in WADA-accredited laboratories or as otherwise approved by WADA.

**International Standard for Laboratories**

The International Standard for Laboratories outlines the operational requirements of a WADA-accredited laboratory as well as the special requirements for testing at major Events such as the Olympic and Paralympic Games.

**IOC Anti-Doping Rules**

The IOC Anti-Doping Rules requires that samples be analysed only in WADA-accredited laboratories or as otherwise approved by WADA.

Further, the choice of the WADA-accredited laboratory to be used should be determined by the OCOG, however, this choice is subject to the approval of the IOC.

The Laboratory shall analyse samples and report results in conformity with the International Standard for Laboratories.

**IPC Anti-Doping Code**

▸ IPC

The IPC Anti-Doping Code requires that samples be analysed only in WADA-accredited laboratories or as otherwise approved by WADA.

# 14.2 Service Agreement & Operations

**Introduction**

This section outlines the operational requirements and responsibilities of the Laboratory and the OCOG in relation to the Laboratory processes.

**Service Agreement**

It is the responsibility of the OCOG to arrange for the services of a WADA-Accredited Laboratory to provide the analyses of the samples as required by the Test Distribution Plan agreed between the OCOG and the IOC/IPC respectively.

It is recommended that a service agreement be established between the OCOG and the chosen laboratory.

While the agreement is a commercial arrangement, it is important to establish an open and cooperative working partnership with the laboratory.

### Contingency Arrangements

The agreement should contain contingency arrangements for new tests developed after the agreement is signed allowing for the flexibility from both the OCOG and the Laboratory to deliver the best Doping Control Programme available at the time of the Games.

**Receipt of the Samples**

The Laboratory will be required to receive samples on a 24 hour, seven day a week basis for the duration of the Games.
The International Standard for Testing and the International Standard for Laboratories both outline the requirements for the OCOG and the laboratory to establish a system to manage the:

- Appropriate receipt of the samples and appropriate documents at the laboratory;
- Completion of documentation to record such receipt;
- Requirement to notify the OCOG that the samples have been received; and
- Issues relating to the receipt and/or condition of the samples.

**Analysis of the Samples**

The laboratory will be required to analysis samples and provide results within the time frame agreed upon between the IOC/OCOG/laboratory from receipt of the samples (with some exceptions).

Continued on next page

# 14.2 Service Agreement & Operations, Continued

**Provision of Analytical Reports**

IPC

The IOC, IPC, and the OCOG will inform the Head of the laboratory of exactly who to and how the results are required to be provided.

This process will be done in conformity with the International Standard for Laboratories and the IOC Anti-Doping Rules or IPC Anti-Doping Code for the Olympic Games and Paralympic Games respectively.

**NOC Visit to Laboratory**

NOCs team doctors and other interested parties may have the possibility to visit the laboratory only upon the laboratory director's agreement and in close collaboration with the IOC Communications Department after the Village opens in the week prior to the opening of the Games.

# 15.0 → WADA Requirements

## Executive Summary

**Introduction** This chapter outlines the WADA requirements and outlines what level of obligation is required to fulfil such requirements

**Obligations** The following table outlines the obligations to WADA and where the obligations are documented:

| Level of Requirement | Reference | Programme/Item | Description |
|---|---|---|---|
| Obligation △ | World Anti-Doping Code ⌑ | Independent Observer Programme | The IOC/IPC is required to authorise and facilitate the Independent Observer's Programme |
| Obligation △ | | Provision of Transport | Approximately 12 cars and drivers to support the WADA programmes and staff |
| Obligation △ | | Provision of Offices/Services/ Assistants (as determined by the IOC) | Offices, Services and Assistants for:<br>• WADA General Office<br>• WADA Athlete Outreach Programme<br>• WADA Independent Observer Programme |
| Obligation △ | | Interpreters, Assistants, and Security | The OCOG shall provide adequate staff/personnel as required. |
| Support | | Delivery of WADA and/or IF Out-of-Competition Testing Programmes | Provide support to WADA/IFs – e.g. Use of facilities, personnel for the WADA programme in the years/months leading up to the Games |
| Support/Partnership | | Delivery of IOC/IPC Games- time Out-of-Competition Testing Programme | Seek assistance from WADA for delivery of the IOC and IPC Games-time Out-of-Competition Testing programmes |

# PART 3 → IOC Medical Commission

## 16.0 → Commission Guidelines

### Executive Summary

**Introduction**

The Medical Commission was created in 1967 in order to deal with the increasing problem of doping in the sports world. The initial goal of putting in place an Doping Control structure was rapidly widened to encompass the following three fundamental principals:

- Protection of the health of athletes
- Respect for both medical and sport ethics
- Equality for all competing athletes

During the Olympic Games, members of the IOC Medical Commission (IOC MC) will participate as working members of the Commission to observe, assess, and support the Medical Services and Doping Control Functions:

- Monitor the doping control tests carried out by the OCOG in accordance with the IOC Anti-Doping Rules and WADA
- Liaise with the team doctors, in the village and at the venues
- Monitor injuries and analyse the medical data provided by Medical Services
- Monitor dental and physiotherapy services in close cooperation with Medical Services.

Continued on next page

# Executive Summary, Continued

**Resources for IOC Medical Commission**

△

At Games-time, the OCOG must make provisions to ensure the IOC MC has adequate resources and a base of operations., Transport on site, , and support for meetings must be provided at no cost to the working members of the IOC MC.

**Contents**

This part contains the following topics:


| Topic |
| --- |
| 16.1 Resources for IOC Medical Commission |

# 16.1 Resources for IOC Medical Commission

**Accommodation**
✕

Several members of the IOC Medical Commission (IOC MC) hold positions on the IOC and, as such, will be housed in the IOC Hotel and will have access to the services and resources provided by Olympic Family Services. The other working members of the Medical Commission participating in the Games must have accommodation according to the Technical Manual on Accommodation.

**Location & Security**

In order to minimise transport requirements, it is helpful if the IOC MC accommodations are in close proximity to the IOC Hotel. The hotel for the IOC MC must have adequate space for the IOC MC offices as described below.

**Offices & Meetings**

The OCOG should provide offices, co-located with the IOC MC accommodations, for the IOC MC base of operations. In addition, the OCOG should provide an office in the village polyclinic for the IOC MC. The OCOG should provide the following requirements for Games-time operations:

- Office for the Chairman of the IOC MC
- Office for the IOC Medical Director
- Office for the IOC Medical Programmes Manager
- Office for the OCOG Chief Medical Officer
- Working area for the IOC MC Secretariat
- Working area for the OCOG Medical Services/Doping Control Secretariat
- A meeting room large enough for a minimum of 30 individuals
- Secured storage for Doping Control supplies

**Accreditation**
✕

The OCOG should ensure appropriate controls for access during Games-time as set out in the Accreditation and Entries at the Olympic Games – User's Guide for all individuals associated with the Medical and Doping Control Programmes to accomplish their work obligations. This includes not only members of the IOC MC, but also any contractors, Medical and Doping Control staff and volunteers that will need access to controlled Olympic venues, the village, the doping control laboratory, or designated IOC / IOC MC hotels.

**NOC Team Doctors' Meeting**

A meeting room should be scheduled for the NOC Team Doctors' meeting, to be held the afternoon on the day before the Opening Ceremony. This is a one-time need, and requires meeting space for approximately 400 individuals for Olympic Games, 200 for Olympic Winter Games, and 50 for Paralympics, with appropriate language services and audio-visual equipment required. This meeting room should be located in the athletes' village, for the convenience of the NOC team doctors.

Continued on next page

# 16.1 Resources for IOC Medical Commission, Continued

**Daily Operations & Meetings**

Daily operations for the Commission include:

- Review of assignments and schedules for IOC MC working members
- Coordination of assigned cars and drivers for IOC MC working members
- Review of Medical Services and Doping Control daily reports submitted by the OCOG

The IOC MC will not implement a daily meeting schedule for the commission, however Impromptu meetings may be held at any time during the Games. Such meetings may require the entire IOC MC to convene and may include invited guests. There may also be impromptu meetings for small working groups.

**OCOG Staffing for Offices**

### OCOG Volunteer Staffing for the IOC MC Secretariat

The OCOG should provide the services of volunteers to work in the IOC MC Secretariat, as required by the IOC. The OCOG should determine what operations will be based at the IOC MC offices and which at MHQ, the polyclinic, and the MOC. There should be a minimum of one member of the OCOG core medical or doping control team scheduled to work at the IOC MC offices in order to provide support for the IOC MC during the working day.

### Interpretation & Translation

Official meetings should be held in English and French, which will require the expert services of simultaneous interpreters.

**Transport Needs**

The working members of the IOC Medical Commission should be provided transport between the venues, villages, the IOC Medical Commission offices, the doping laboratory and the IOC hotel in order to fulfil their Games-time work assignments, as determined by the Technical Manual on Transport.

Transport of samples and documentation is covered in the earlier chapter on the Testing Process.

Continued on next page

# 16.1 Resources for IOC Medical Commission, Continued

**Communication Protocols**

### Routine Communication

Routine communication to the IOC MC should include scheduled updates regarding qualitative and quantitative information about the daily operations of the Medical and Doping Control programmes.

### Urgent Communication

Urgent communication protocols should be developed for notification of:

- Significant injuries or illnesses of athletes or other OF members
- Significant incidents occurring at the venues, including injuries or illnesses of non-OF members, as well as relevant but non-medically related incidents that have been escalated to the OCOG's main operations centre (MOC)
- Event schedule changes

The OCOG's Chief Medical Officer (CMO) or his designee will be responsible for communications with the OCOG's MOC, public health agencies, and the Olympic hospitals. The IOC Medical Director or the Chairman of the IOC MC will be responsible for communications with the IOC and/or the IOC Executive Board.

Communication protocols should also be developed to facilitate communication between OCOG staff and volunteers and the community-based and/or contracted service providers, including what will be communicated, when, and how.

**The Medical Services Communication Network should include**:

- IOC MC
- Medical Services core team
- Venue medical officers
- NOC team doctors
- OCOG Main Operations Centre
- Public health officers
- Hospital Olympic liaison officers (HOLOs)
- EMS dispatch
- Disaster response agencies

**The Doping Control Communication Network includes:**

- IOC MC
- Doping Control core team
- Venue doping control officers
- Doping control laboratory director
- NOC team doctors
- Medical Directors of the IFs
- OCOG Main Operations Centre

Intra-venue communications are addressed in Venue-based medical services chapters 2 and 3, as well as Part 2 on Doping Control.

Continued on next page

# 16.1 Resources for IOC Medical Commission, Continued

**Daily Reports Provided to IOC**

The following reports should be provided to either the Chairman of the IOC MC or to the IOC Medical Director.

### Daily Summary of Doping Control Activities

- Number of tests
- Summary of results
- Operational issues or concerns

### Daily Summary of Medical Services

- Quantitative medical data (number of medical encounters, EMS transports, disposition of patients, etc.)
- Qualitative data (status report for any critical injuries or illness, etc.)
- Operational issues or concerns

**Post-Games Reporting**

The IOC and OCOG leadership will provide information to OCOG Medical Services regarding the content and format of information to be supplied for the Olympic Games Knowledge Reports. OCOG Medical Services should plan, in advance of the Games, to document adequately its planning and operational activities so that the after-Games reporting will be more complete.

**Uniforms**

The IOC MC should be provided Games-time uniforms.