An Advocacy of a Modified Double Standard for Research in Developing Countries

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Advances in medical technology and treatment procedures have brought about a need for international research. New medications are being developed that are designed specifically for developing areas across the world. These treatments are less costly, easier to use, they represent a massive shift in the focus and goals of pharmaceutical companies. However, this trend has also led to a change in how research is conducted. With treatments directed towards individuals in developing nations, research must occur in these regions in order to determine efficacy for the intended population. To perform this research, some investigators decide to use placebo trials despite the availability of better treatments with which to compare the trial medication. They justify this by claiming that the better treatments can be quite costly and are widely available only in developed nations. The standard of care in the developing nation where research is being conducted is quite different from the researcher's native country and it does not mandate that certain expensive options be used.

This presents us with an interesting ethical dilemma. Which ethical standard of care ought to be followed when conducting international research? The standard of care delineates how the research is conducted, the level of compensation provided for subjects, and what ancillary care is provided to said subjects amongst other factors. There are two options available. The first is a single standard based upon the best possible treatment options available, echoing the standards of research used in developed nations, implying that researchers cannot use placebos unless absolutely necessary and ancillary care that would be provided in a study in a developed nation would be provided in this case. A contrasting standard allows researchers to tailor their practices to the location in which their research is conducted. If an alternative medication is not widely available to test against, placebo trials are used and ancillary care is provided based upon what the standard of care is in the nation where the study is occurring. So which should researchers default to? Do they have an obligation to provide the best possible alternatives or are placebos acceptable

for foreign research? Does the ancillary care provided have to be the best option available? The answers to these questions are not explicit in the current debate . In fact, the best solution for international research is a blend of the two models that prevents researchers from conducting studies based upon the lowest common ethical denominator and does not require the provision of treatment only available to the wealthiest individuals. In order to understand this mixed approach, let us first examine both standards.

The desire for a single standard rose from the need to protect subjects of research in developing nations. The lowest common denominator argument[1] illustrates this point perfectly. Researchers often find that the legal standards required to perform research are often less strict in developing nations. Studies that would get denied instantly by an institutional review board in a developed nation are accepted and sometimes encouraged in the developing world. Because of these lower standards, researchers would act to the lowest common ethical denominator. Instead of acting as they would in a study based in their home country, researchers can maintain minimal standards for their experiments. They do so by denying ancillary care and conducting placebo trials since the comparative treatment options that would be mandated in developed nations are not available in less developed areas. They do enough to minimize the harm caused to their subjects, but nothing more. However, Ruth Macklin argues that if we have any belief in the concept of beneficence, researchers need to do more:

If the principle of beneficence has any relevance to the conduct of research, it requires researchers to maximize benefit in as well as to minimize harms. Since the research subjects themselves are surely among those who should be counted in seeking to maximize benefits, it follows that providing a higher standard of care during the research, when that is feasible, is ethically preferable to providing the minimal standard dictated by background conditions in the country or region.[2]

Essentially, researchers cannot simply minimize harm to the subjects they are experimenting on and call it a day. Since the goal of research is to create a treatment that would maximize benefits, that maximization ought to apply in the research process as well as in the results.

Despite Dr. Macklin's argument, the single standard approach does have its drawbacks. The primary issue is the problem of undue inducement. The research pool for a study is considered less valid if the subjects are unduly induced into entering the experiment. Essentially, researchers cannot give participants an offer they cannot refuse in order to increase the number of enrollees. Undue inducement presents us with two unique dilemmas. First, it entices people to enter into a study that they would not participate in normally. For example, if a researcher paid a high level of compensation for a study performed in a lower income area, people would be clamoring to enter. However, they would be participating for reasons other than the point of the research, tainting the results. This issue would be magnified if researchers entered a developing nation promising ancillary care that individuals would never be able to afford or receive otherwise (for example, prescription medications or therapies that require specific infrastructure or have an excessive cost). This undue inducement of participants makes the outcome of the study questionable at best. This is also ethically problematic because people could be forced into participating in research in order to receive healthcare that they would not get otherwise. Although it is not outright coercion, undue inducement still persuades individuals to be subject to potentially dangerous research for dubious reasons. This element of undue inducement violates two of the primary tenets of principlism. First, it violates autonomy because the individual has their choice removed from them via the level of ancillary care provided. They are presented with an offer they cannot refuse.

Excessive ancillary care pushes individuals into the study instead of having them enter as willing participants. Second, undue inducement harms justice because an individual is exposed to risks that they would not normally have to face. Inducement makes individuals agree to do things they would not do otherwise. Participation in a trial under these circumstances is unjust. While the four principles can never be perfectly met and are sometimes at odds with each other, we cannot ignore the problem that undue inducement presents.

The second dilemma presented is a more logistical one. Since individuals in developing areas will be clamoring to enter the study because of the benefits provided, they may falsify medical information in order to gain entry. In developing countries, records are often poorly kept, so what the individual tells the researcher about their medical history is all that the investigators will get. Over-the-top ancillary care will make people lie about pre-existing conditions in order to become research subjects. This has two implications. First, the data collected becomes questionable at best. A pre-existing condition could interfere with the results of the study, possibly pushing researchers towards a false conclusion. Second, the trial medication could have adverse effects on the individual because of their undisclosed health issues. If the subject lies to the investigator about conditions that would conflict with the study, they cannot be informed about potential risks specific to their case.

The double standard follows a more pragmatic approach. Researchers argue that since they are conducting research in a different nation, they should follow the ethical guidelines of wherever the study is taking place. As mentioned previously, this leads to placebo experiments and the inadequate provision or the outright denial of ancillary care. Those who conduct experiments in developing nations claim that since the best or most advanced treatment in the world is not available in the country where they are conducting research, they are not obligated to provide them. Additionally, some claim that it is feasibly difficult to actually operate or distribute the best available option. Some medications are just too expensive for a researcher to provide without increasing the cost of the study too greatly. However, is the increased cost of using the best treatment instead of a placebo enough to outweigh maximizing the benefits for the research population? Most would argue no. At the point at which researchers are using disadvantaged subjects to test a medication that will create a profit for the sponsoring organization, the participants ought to be due something a bit better than a placebo. On top of this, the double standard bites into Macklin's lowest common denominator argument. When it comes to the lives of individuals, there is no reason to operate at the lowest ethical standard. Since participants in research are subject to potentially dangerous experimental medication, they deserve better than the easiest standard that researchers could manage to meet.

So who is right? Which standard ought to be applied? In my estimation, the correct answer is both. To be more specific, I believe in a modified double standard. By providing the best possible treatments and meeting the standard of care in developed nations, researchers are forced into a difficult burden of paying for and providing medication that is only readily available in wealthy areas and unduly inducing individuals into participating, which could taint the value of their research. However, researchers have a greater obligation to their subjects than to provide absolutely nothing. Therefore, I believe that researchers should provide ancillary care that is not overly difficult to provide such as medications that are available to the average citizen in their home country that might not be for individuals in developing nations. Also, researchers should not be able to use the lower standard of developing nations in order to skirt around basic procedural practices such as maintaining a clean and safe testing environment or keeping adequate records and results. Doing so maximizes the benefits of research participants to a point that triggers much less undue inducement than the single standard would.

There are two arguments that could possibly be used to counter the modified double standard. First, some individuals claim that undue inducement will occur anyway. Even the medication being tested is more than individuals in developing areas would be able to receive on a regular basis, meaning that they could be induced to participate in the study regardless of any ancillary care. However, this is a burden that all studies carry. No matter what, there will be an element of inducement. Nevertheless, researchers ought to attempt to minimize undue inducement as much as possible. The less that undue inducement occurs, the less likely the subject pool will be tainted by those who participate for faulty reasons. The level of inducement provided by the research itself pales in comparison to what providing the same level of healthcare that developed nations receive would cause. Even though some inducement is inevitable, the modified double standard reduces it as much as possible in order to preserve the quality of results. A second argument that could be used against the modified double standard is that researchers have a greater obligation to provide justice and equity than to preserve the subject pool. As stated before, individuals participating in risky experiments ought to be due more than just a placebo and some Tylenol. Instead, the just thing to do would be to provide the best available treatments instead of a placebo and to give ancillary care comparable to what would be offered in a study conducted in a developed nation. However, one cannot ignore the harm that undue inducement causes. If providing a level of ancillary care unlike anything research participants could ever get on their own nullifies the results of the experiment, then the individuals involved in the study subjected themselves to potentially dangerous research for nothing. One must consider the scope and future results of research before making claims about justice. If providing a lesser level of ancillary care means the results of research are preserved and can go on to help future generations of individuals in developing nations, then it is more just.

At the end of the day, it is clear that participants in international research are due more than the lowest common ethical denominator concerning standard of care. However, we cannot harm the results of research by forcing researchers to provide the best available treatments and care in the world. Therefore, researchers ought to use the modified double standard proposed earlier. It avoids the pitfalls commonly associated with the traditional double standard while placing realistic burdens on researchers to provide care for subjects as much as possible. Because it preserves the outcome of research while still providing participants in experiments clear benefits, the modified double standard is the best compromise to use in international studies in developing nations.

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REFERENCE NOTES

[1] Ruth Macklin, Double Standards in Medical Research in Developing Countries, (Cambridge: Cambridge University Press, 2004), 59.

2 Ibid