EThICAL ISSUES IN HEALTH RESEARCH

A MANUAL FOR INTRODUCTORY TRAINING

EThICS TRAINING RESOURCE GROUP, INDIA
2007
The Ethics Training Resource Group, India consists of a network of individuals committed to promoting bioethics training amongst biomedical and social sciences researchers in India. The Group has brought together varied resources to conduct trainings across the country independently and in collaboration with national and local institutions, including the Achutha Menon Centre for Health Science Studies, Centre for Social Studies, Tata Institute for Social Sciences, Samuha and the Indian Council for Medical Research.

This manual is a result of several years of such collaborative training efforts. The modules in this manual represent only a sample of those that the Group has developed. We hope to update this compilation and look forward to others enhancing them. Many individuals have contributed including (but not limited to) Sunita Bandewar, Lester Coutinho, Amar Jesani, Suneeta Krishnan, Neha Madhiwala, Sailesh Mohan and Mala Ramanathan.

The manual has been edited by Amar Jesani, Suneeta Krishnan Karl Krupp and Mithu Tharayil.

We gratefully acknowledge financial support from the University of California, Berkeley - University of California, San Francisco Fogarty International AIDS Research Training Program (Grant TW00003-15) for compiling this manual.

(Version May 2007)
TABLE OF CONTENTS

INTRODUCTION

PREPARATORY MATERIALS

- Timeline for organizing a workshop
- Tips on organizing a workshop

TRAINING MODULES

- Module overview
- Module 1: Bioethics theories and principles
- Module 2: Informed consent
- Module 3: Privacy and confidentiality
- Module 4: Ethical issues in HIV research
- Module 5: Standards of care
- Module 6: Integrity in research
- Module 7: Risks and benefits: analysis and safety monitoring
- Module 8: Overview and functions of institutional ethics committees

SAMPLE DOCUMENTS

- Workshop outline
- Evaluation form
INTRODUCTION

Training and dialogue on research ethics and protection of human participants is a relatively recent development in India although health research has a long history. Scholarship on ethics may be said to have formally begun with the printing of the Indian Journal of Medical Ethics (IJME) about 15 years ago. The first national conference on bioethics was held by the IJME just two years ago - in 2005 and was attended by over 400 individuals. While there appears to be a growing interest in bioethics, there continues to be a need for increased awareness and activity amongst the Indian research community.

A group of individuals at institutions across India came together in 2003 to develop and implement an introductory training program on ethics in health research. We recognized the need to ground research ethics training in the socio-cultural, economic and legal realities of India. To this end, we developed a series of training modules that explore the application of Indian and international ethics guidelines in local research settings. As part of this effort, we have begun to develop Indian case studies. At the end of 2006, we had conducted six three to five-day training workshops on ethics in health research.

Training needs in India, however, are great and the capacity for training must be expanded considerably. We have developed this manual to aid those interested in conducting introductory training workshops on ethics in health research. We recommend that those using the manual undergo a formal training program in ethics prior to organizing one on their own. This manual has not been designed as a self-study tool. There are several on line ethics training programs that may be better suited to self-study. Rather, we have aimed to provide a guide to organizing group-based trainings.

The modules included in this first version of the manual are the core set of modules that we believe should be included in an introductory training on research ethics (excepting the specialized module on HIV research). We envision adding several modules on topics such as justice and equity, ethics and power relations in research, data management and analysis, and action/intervention research in future editions.

Each module consists of notes to the facilitator (including suggested readings) and a PowerPoint presentation. In addition to the eight modules, we have included preparatory materials - guidelines for organizing a training workshop.

We urge those using this manual to edit, improve and tailor these materials. We also encourage you to send us your feedback and questions to suneeta.krishnan@gmail.com.
PREPARATORY MATERIALS
TIMELINE

This is only a suggested timeline and is based on our experiences planning and hosting this training. Ideally, you will have three months to plan this training, though it can be done more quickly if you work fast!

Three Months Prior to Workshop
- Identify resource people
- Invite resource people for a planning meeting (optional)

Two Months Prior to Workshop
- Hold consultation with resource people (optional)

If holding planning meeting, two days are recommended to familiarize resource people with material, with one another, and designate who will be leading each session. At the end of the meeting, resource people should feel comfortable with the material and be assigned to lead specific sessions. Resource people may take home sample PowerPoint presentations (from this manual) for their sessions and adapt them to fit their personal style and the audience. Case studies may also be adapted.

- Confirm session plan and assign sessions to resource people.
- Set date of event
- Send invitations to resource people; request finalized presentations and case studies for 2 weeks prior to event
- Send preliminary invitation to participants; include schedule if known
- Identify venue
- Identify potential valedictory speakers
- Send invitation to potential valedictory speaker
- Confirm valedictory speaker and resource people
- Request bio data from resource people and valedictory speaker and create bio sheet for participants
- Request travel itinerary from resource people (recommend that they come on the afternoon prior to the start of the training for a meeting that evening)
- Reserve accommodations for resource people, if needed

One Month Prior to Workshop
- Order/purchase supplies: folders, pens, notebooks, nametags, food
- Send reminder to resource people for presentations and case studies
- Send reminder invitation to potential participants
- Burn copies of Ethics Resource CD
- Print case studies for participants

Within One Month of the Workshop
- Arrange transportation for resource people, if needed
- Send reminder to confirmed participants with schedule and directions to venue
Compile Participant Packets with: folder, schedule, case studies, pen, notebook, resource people bios

**Week of the Workshop**
- Meeting of resource people to go over the details of the training
- Hold training!
TIPS

A number of ideas and lessons have emerged during the development and implementation of this manual. We have summarized these below. Of course, this is not an exhaustive list and we are sure that you will identify other equally important issues.

- **Criteria for Resource People**
  When identifying individuals to invite as resource people, keep in mind the following criteria:
  - Knowledge of subject
  - Ability to convey ideas effectively
  - Comfort speaking in front of audiences
  - Ability to handle questions
  - Ability to engage audience in conversation

- **Resource Meeting**
  Once resource people are confirmed, set up a meeting for the afternoon or evening prior to the start of the training. During this meeting resource people can get to know one another (if they don’t already), and work out their roles for the training. Additionally, this gives everyone an opportunity to address any concerns or answer any questions that may be pending as well as go over the flow of the training and define their roles.

- **Faculty Biographies**
  It may be useful to include biographies of the resource people leading the training. This allows participants to get to know the background of their instructors as well as provide networking opportunities between faculty and participants.

- **Distribute participant list for future contact**
  Providing participants and faculty with the contact information for all attendees facilitates networking and encourages dialogue about topics discussed during the training after it is complete. Be sure to seek permission from individuals prior to distributing information.

- **Type of Training**
  We identified two types of trainings – residential versus local. In a residential training, participants are provided accommodations for the duration of the training and required to stay. A residential training increases the amount of time that participants are in the training and allows time for evening activities related to the topics. However, it requires an increased commitment from participants to stay for the duration of the training. A local training is possible if most participants reside within the area of the training. Days last between six and eight hours (depending on the number of sessions) and participants go home at the end of each day. Evening activities can be planned but participation should probably be optional.

- **Evening Activities**
  In addition to daily sessions, evening activities can be included to supplement topics covered during the training. Evening activities may also present material in a format different from
lectures. Instead, movies, role plays, and discussion groups may stimulate further conversation. Additionally, a participant project review can be arranged for participants to share their work with one another and reflect on ways to integrate training lessons into their projects and research.

- **Case Studies**
  We found participants enjoyed starting a session with case studies and then having the presentation. Often many of the presentation topics are raised when participants are discussing the case studies. The challenge for the facilitator is to link case study discussions to the presentation without sounding redundant. The presentation can serve as a reinforcement and summary of topics covered in case study discussions.

  *Please check that:*
  - Case studies are final edited version
  - Adequate photocopies are made
  - There is no overlap with the case studies to be used for other sessions

- **References**
  The Facilitators Notes for most of the session included in this manual have a section of Recommended Readings. These readings can be found on the Ethics Resources CD that comes with this manual. It may be helpful to have copies of these articles available for participants to reference. It may also be helpful for facilitator’s to review these materials for additional background information on their session topic.

- **PowerPoint Presentations**
  We have included slides for each of the sessions with this manual. Feel free to modify them to suit the style of the facilitator and content of the session.

  *Please check that:*
  - The presentation stays within the allocated session time
  - Try to keep text on slides to a minimum. Use slides as an aide, rather than putting all the information on the slides
  - Consider color schemes - especially the contrast between backgrounds and letters, font type and size
  - Upload and test presentations on the equipment that will be used during the session in advance
TRAINING MODULES
MODULE OVERVIEW

Module 1: Bioethics theories and principles
- To appreciate what the study of ethics entails.
- To be able to identify the theories underlying bioethics.
- To understand how the bioethics movement has developed.
- To be able to identify the basic principles of bioethics.

Module 2: Informed consent
- To understand the meaning of “informed consent.”
- To appreciate the challenges of implementing “informed consent” in research settings.
- To be aware of the ways researchers respond to these challenges.

Module 3: Privacy and confidentiality
- To be familiar with the concepts of “privacy” and “confidentiality” and their application in research ethics.
- To understand ethics guidelines on “privacy” and “confidentiality.”
- To appreciate the challenges to “privacy” and “confidentiality.”
- To understand legal recourse and protections afforded to study participants, and the obligations required of researchers.

Module 4: Ethical issues in HIV research
- To recognize how the context of HIV/AIDS contributes to unique challenges in research ethics.
- To identify the ethical issues involved with HIV/AIDS research.
- To integrate the principles of research ethics into the study of HIV/AIDS.

Module 5: Standards of care
- To understand the different approaches used to evaluate ‘standard of care’ (SOC) in health research.
- To identify the advantages and disadvantages of each approach to SOC in health research.
- To be aware of the main sources of national and international guidance.
- To understand the issues and debates surrounding ‘standard of care’ in health research in India.

Module 6: Integrity in research
- To understand the importance and core values of integrity in research.
• To recognize the issues and challenges of publication and authorship and be able to identify sources of guidance on the participant.

• To define types of misconducts in research and strategies to avoid and rectify them.

• To understand the concept of conflict of interest (COI) and be able to identify and deal with it in research and ethical review of studies.

Module 7: Risks and benefits: analysis and safety monitoring

- To identify the various types of risks and benefits involved in research and how the ethical principles are applied to evaluate them.
- To define the concept of minimal risk within research.
- To identify methods to anticipate and mitigate risk within research.
- To understand the burden of risk borne by vulnerable populations.
- To identify the components of a Data Safety Monitoring Plan.

Module 8: Overview and functions of institutional ethics committees

- To be familiar with the history, purpose, and makeup of Institutional Ethics Committees (IEC).
- To understand their role and mandate.
- To be able to identify research activities requiring ethical review.
- To understand the procedures and standards IECs use to make decisions.
Module 1  
Bioethics Theories and Principles

By the end of the day the participants will be able to do the following:

- Appreciate what the study of ethics entails.
- Be able to identify the theories underlying bioethics.
- Understand how the bioethics movement has developed.
- Be able to identify three basic principles of bioethics.

Preparatory Readings:


Training Schedule:

Time: 1 hour (45 minutes for presentation and 15 minutes for discussion)

Facilitator Notes:

Presentation (45 minutes):

Slide One: Module Title
Slide Two: Presentation Overview
Slide Three: A working definition of ethics

Three Definitions:

1. “Ethics is a code of values which guide our choices and actions and determines the purpose and course of our lives.”  
   Ayn Rand, Russian-American novelist and philosopher (1905-1982)

2. “Ethics is nothing else than reverence for life.”
   Albert Schweitzer, German medical missionary, theologian, musician and philosopher. Winner of the 1952 Nobel Peace Prize (1875-1965)

3. “The discipline dealing with what is good and bad and with moral duty and obligation.”
   Merriam-Webster Dictionary

Slide Four: Ethical theories underlying bioethics

Ethical theories usually utilized in bioethics have competing, and partially overlapping frameworks:

- Theories that focusing on the development of individual character (Virtue Ethics).

- Theories based on the idea that what is right, is what will bring the most happiness to the most people (Utilitarianism).
• Theories that are rule-based and proceed from the idea that people have a “duty” to do certain things (Deontology).

• Ethical systems which focus on the inter-relationship of society and the groups and individuals within it. (Communitarianism, Feminist ethics).

---

**Slide Five: Virtue Ethics**

Virtue ethics theories were based primarily on the teachings of Aristotle (384-322 B.C.) and his student, Plato (427-347 B.C.). Both philosophers emphasized reason and logic as essential tools for finding answers to ethical questions. The central focus of virtue ethics is the development of good personal character. The goal of ethics, according to Aristotle in his landmark work Nicomachean Ethics (350 BC), was the search for "the good life," the pattern of specific personal virtues that people should adopt to find happiness and fulfillment. Plato and Aristotle both believed that the virtues of wisdom, courage, temperance, and justice were the most logical choices to help people achieve this goal.

**Slide Six: Utilitarianism – history**

Utilitarianism has a long history. It was first proposed by Mozi (490-403 BC) one of China's first philosophers. He advocated using general welfare as a criterion of the correct dao-guiding discourse and equal concern for everyone as an overriding principle.

European Utilitarianism is identified with the writings of Jeremy Bentham (1748-1832) and James Mill (1773-1836). They advocated the principle and goal of "the greatest happiness of the greatest number". The approach to finding happiness was focused on achieving the greatest amount of
pleasure and least amount of pain. The goal of education was to form positive associations with actions for social good and negative associations with things that were socially hurtful.

Slide 7: Utilitarianism

Bentham's moral theory was founded on the assumption that it is the consequences of human actions that count in evaluating their merit and that the kind of consequence that matters for human happiness is just the achievement of pleasure and avoidance of pain. He argued that the hedonistic value of any human action is easily calculated by considering how intensely its pleasure is felt, how long that pleasure lasts, how certainly and how quickly it follows upon the performance of the action, and how likely it is to produce collateral benefits and avoid collateral harms. Taking such matters into account, we arrive at a net value of each action for any human being affected by it.

Mill fully accepted Bentham's devotion to greatest happiness principle as the basic statement of utilitarian value but he did not agree that all differences among pleasures can be quantified. On Mill's view, some kinds of pleasure experienced by human beings also differ from each other in qualitative ways, and only those who have experienced pleasure of both sorts are competent judges of their relative quality. This establishes the moral worth of promoting higher (largely intellectual) pleasures among sentient beings even when their momentary intensity may be less than that of alternative lower (largely bodily) pleasures. Even so, Mill granted that the positive achievement of happiness is often difficult, so that we are often justified morally in seeking primarily to reduce the total amount of pain experienced by sentient beings affected by our actions. Pain—or even the sacrifice of pleasure—is warranted on Mill's view only when it results directly in the greater good of all.

Against those who argue that the utilitarian theory unreasonably demands of individual agents that they devote their primary energies to the cold-hearted and interminable calculation of anticipated effects of their actions, Mill offered a significant qualification. Precisely because we do not have the time to calculate accurately in every instance, he supposed, we properly allow our actions to be guided by moral rules most of the time. Partly anticipating the later distinction between act and rule utilitarianism, Mill pointed out that secondary moral principles at the very least perform an important service by providing ample guidance for everyday moral life. Finally, however, he emphasized that the value of each particular action—especially in difficult or controversial cases—is to be determined by reference to the principle of utility itself.

Taken from: “The Nineteenth Century” by C. L. Ten

Slide 8: Utilitarianism – strengths & weaknesses

Strengths of Utilitarianism:

- It is consistent with a common sense intuition that the consequences of actions are important.
- It provides a basis for formulating and testing policies.
- It provides an objective way of resolving conflicts of self-interest.
- It is egalitarian and impartial.

Weaknesses of Utilitarianism

- Utilitarianism ignores actions that appear to be wrong in themselves.
- Measuring consequences can be difficult or impossible.
• The principle of utility may come into conflict with other principles that can be considered fundamental such as justice.

Slide 9: Deontology

Immanuel Kant laid the foundations for the theory of deontology, or the study of duty, in his book “The Foundations of the Metaphysics of Morals (1785). In Kant’s view, what gives actions moral worth is not the consequences of those actions, but the motives behind them. Kant provided not so much a list of duties as a procedure for determining them. The procedure that specifies the content of duty is called a categorical imperative or “unconditional command” of morality. Kant defined two main forms of the categorical imperative:

1. “Act only on that maxim through which you can at the same time will that it become a universal law.”

A maxim in Kant’s theory is a plan of action, so here he gives us an ethical test for our intended actions, presumably to be used before we commit them. The point of the test is that we ought to be able to endorse the “universal” acceptability of the plans or intentions behind our actions. We should not be partial to our plans simply because they are ours; they must be acceptable from any point of view. Maxims that cannot be universalized will produce logical contradiction or “disharmony” when they are run through the test of the categorical imperative. The grounding or validation of this principle lies in the universality of practical reason. For Kant, our ethical duties arise from what is common to us as rational beings. Humans have a kind of freedom which is gained in “creating”

2. ”Act in such a way that you always treat humanity [yours or another person's] never merely as a means but always at the same time as an end-in-itself.”

This special moral status or intrinsic value implies that humans ought never to be valued as less significant than things that have merely instrumental value. Things of instrumental value are mere tools, and though they can be traded off with one another, they can never be more important than intrinsically valuable things. Significantly, all technology is in some sense a mere tool; no matter how many resources our society pours into technologies, the moral status of humans is supposed to trump the value of mere tools. Kantian duties are designed to protect that status.

Taken from: Deontology. The Encyclopedia of Science, Technology, and Ethics, ed. Carl Mitcham, Gale Group Publishing

Slide 10: Imperatives

Hypothetical vs. Categorical Imperatives- imperatives are formulas for determining the course of actions. According to Kant, if an action is good merely as a means to something else, then the imperative is hypothetical; if it is represented as good in itself, hence necessary, as the principle of the will in accord with reason, then it is categorical.

Forms of imperatives:

(1) A hypothetical imperative is an imperative of the form “Do X so as to achieve Y.”
(2) A categorical imperative is an imperative of the form “Do X.”
Slide 11: Duties

Perfect duties are duties which can be perfectly satisfied, like the duty not to steal, or not to murder. Imperfect duties are, on the contrary, always imperfectly satisfied, like the duty to help others. There is always more one could do along the lines of satisfying these duties. There accordingly must be some discretion involved in the satisfaction of the imperfect duties in a way that is not involved for the perfect duties. I must select whom to help and whom not to help, but there are no such moral options when it comes to whom to make a false promise to.

This is not to say that Kant thinks that imperfect duties are optional. No, they are hard and fast duties, not mere moral afterthoughts. But they can never be 100% fulfilled (for there is always more one could do). Contemporary thinkers usually use different terms for this distinction, but it is the same point: negative and positive duties. So negative duties would be the thou-shalt-not's (varieties of "bring no harm"), and positive duties are the thou-shalt's (varieties of "bring aid").

*Taken from: Reading notes for Kant’s Grounding for the Metaphysics of Morals (Hackett’s Ellington translation)*

Slide 12: Deontology – Strengths and Weaknesses

Strengths of Deontology

3. Kant’s ethics introduce a needed humanistic dimension into decision making.

4. It attempts to set clear moral boundaries that are universal and consistent.

5. It provides for the possibility of multiple principles and allows for flexibility

6. It provides a framework for individual human rights.

Weaknesses of Deontology

- It is counter intuitive to identify basic moral principles without any consideration of the consequences of actions.

- It can seem overly ‘legalistic’ and focused on rules.

- It does not provide guidance for how to resolve moral dilemmas that where moral imperatives are in conflict.

Slide 13: Communitarianism

Communitarianism is a social philosophy that maintains that society should articulate what is good—such articulations are both needed and legitimate. Communitarianism is often contrasted with classical liberalism, a philosophical position that holds each individual should formulate the good on his or her own. Communitarians examine the ways shared conceptions of the good (values) are formed, transmitted, justified, and enforced. Hence their interest in communities (and moral dialogues within them), historically transmitted values and mores, and the societal units that
transmit and enforce values such the family, schools, and voluntary associations (social clubs, churches, and so forth), which are all parts of communities.


**Slide 14: Communitarianism**

*On the roots of Communitarianism:*

In the 1980s, Charles Taylor, Michael Sandel, Michael Walzer, and Robert Bellah and his associates criticized the excessive individualism of classical liberalism exemplified by the United States under President Reagan and Britain under Prime Minister Margaret Thatcher. In 1995, Alan Ehrenhalt’s book *The Lost City: The Forgotten Virtues of Community in America* questioned the value of enhancing choice, achieved at the cost of maintaining community and authority. In his book *Bowling Alone* (2000), Robert Putnam identified what he deemed “social capital” – the element of communities that forms affective bonds among people – and stressed the importance of “bridging social capital,” in which bonds of connectedness are formed across diverse social groups.


*On positive rights:*

Central to many communitarians' philosophy is the concept of positive rights; that is, rights or unalienable guarantees of certain things. There is wide disagreement about what rights should be guaranteed but some of the more widely proposed rights are those to an education, affordable housing, a safe and clean environment, universal health care, and a job. Positive rights have a long tradition and have been codified in the Universal Declaration of Human Rights and in many 20th-century constitutions.

**Slide 15: Communitarianism, cont.**

*On individuals and the state:*

“Communitarians take issue with the idea that the individual stands and should stand in direct unmediated relationship with the state and with society. This is an idea that flows through a great deal of contemporary legal and political thought in northern countries. Communitarians argue for the continuing significance of status and local networks, and the potential of other intermediate institutions”

*On Communitarian values:*

*Communitarians promote a distinctive set of values.* They value community itself, and tradition. They will also argue for debate and dialogue about what constitutes the significant values in a particular society - there cannot be a universal list for what is important will depend upon the traditions and ways of life in that society


**Slide 16: Communitarianism – Strengths and weaknesses**

Ver may07
Strengths:

- Encourages the protection of diverse traditions and cultures.
- Promotes engagement with key stakeholders in ethical decisions.

Weaknesses:

- The provision of positive rights for some may be a violation of rights for others.
- Communitarianism doesn’t provide guidance for moral concerns that bridge societies.

Slide 17: Feminist ethics

On the male gendered nature of traditional ethical theories:

“Feminist Ethics is an attempt to revise, reformulate, or rethink those aspects of traditional western ethics that deprecate or devalue women's moral experience. Among others, feminist philosopher Alison Jaggar faults traditional western ethics for failing women in five related ways. First, it shows little concern for women's as opposed to men's interests and rights. Second, it dismisses as morally uninteresting the problems that arise in the so-called private world, the realm in which women cook, clean, and care for the young, the old, and the sick. Third, it suggests that, on the average, women are not as morally developed as men. Fourth, it overvalues culturally masculine traits like independence, autonomy, separation, mind, reason, culture, transcendence, war, and death, and undervalues culturally feminine traits like interdependence, community, connection, body, emotion, nature, immanence, peace, and life. Fifth, and finally, it favors culturally masculine ways of moral reasoning that emphasize rules, universality, and impartiality over culturally feminine ways of moral reasoning that emphasize relationships, particularity, and partiality.”


On the ethics of care:

Carol Gilligan, in her book “A Different Voice”, suggested that "justice-based" ethical theories were typical of the way men approached ethics, but did not reflect the a more women-centered ethic of care that centered on responsiveness in an interconnected network of needs, care, and prevention of harm. Supporters of an Ethics of Care emphasize the mutual interdependence of people and the unique role emotions play in our moral lives. According to Gilligan, "...many human relationships involve persons who are vulnerable, dependent, ill, and frail ... [and] the desirable moral response is attached attentiveness to needs, not detached respect for rights" and "The person who acts from rule-governed obligations without appropriately aligned feelings such as worry when a friend suffers seems to have a moral deficiency.” She argues that these features have a role in ethics, allowing us to grasp a situation that may not be immediately available to one arguing solely from a 'justice perspective.'


Slide 18: Feminist ethics, cont.
Among the salient features of feminist ethics:

- It focuses on actions, the outcomes of actions and the nature of agents.
- Consequences are morally relevant but not exclusively so.
- Persons are intrinsically valuable.
- Social justice is an overriding concern.

**Slide 19: Bioethics**

The term "bioethics" was first used by the biologist Van Rensselaer Potter who used the term to refer to a new field devoted to human survival and an improved quality of life. Gradually, the term "bioethics" came to refer to "the broad terrain of the moral problems of the life sciences, ordinarily taken to encompass medicine, biology, and some important aspects of the environmental, population and social sciences. The traditional domain of medical ethics would be included within this array, accompanied now by many other topics and problems."


**Slide 20: Brief History of Bioethics**

- (1947) The Nuremberg Code - The tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human participants in reaction to gross abuses in human experimentation performed in Nazi Germany:
  - The voluntary consent of the human subject is absolutely essential.
  - The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature.
  - The experiment should be so designed and based on the results of animal experimentation and knowledge of the natural history of the disease or other problem under study that the anticipated results justify the performance of the experiment.
  - The experiment should be so conducted as to avoid all unnecessary physical and mental suffering and injury.
  - No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except, perhaps, in those experiments where the experimental physicians also serve as participants.
  - The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment.
  - Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.
  - The experiment should be conducted only by scientifically qualified persons.
During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.

During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

(1964) Declaration of Helsinki was issued by the World Medical Association establishing recommendations to guide medical doctors in biomedical research involving human participants. It included similar recommendations as the Nuremberg Code but added guidance which further distinguished therapeutic from non-therapeutic research. Subsequently, it was revised by the 29th World Medical Assembly, Tokyo, Japan, 1975, and by the 41st World Medical Assembly, Hong Kong, 1989.

Slide 21: Brief History of Bioethics, cont.


(1979) The National Commission for the Protection of Human Participants drafted the Belmont Report, a foundational document in for the ethics of research involving human participants. The report, named after the Belmont Conference Center at the Smithsonian Institution where the document was written, sets forth the basic ethical principles underlying the acceptable conduct of research involving human participants. Those principles, respect for persons, beneficence, and justice, are now accepted as the three quintessential requirements for the ethical conduct of research involving human participants.

Slide 22: Basic bioethics principles

The Belmont report outlines 3 principles for research on human participants:

1. Respect for Persons: This principle incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.

Slide 23: Basic bioethics principles, cont.

Ver may07
2. Beneficence and Nonmalificence: Research participants must be treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being.

3. Justice: The burdens and benefits of research should be distributed fairly.

**Slide 24**: Discussion (15 minutes)
Bioethics Theories and Principles

Basic Training on Ethical Issues in Health Research

Module 1
Presentation Overview

- A working definition of ethics
- Ethical theories underlying bioethics
  - Virtue-based ethics
  - Results-based ethics
  - Duty-based ethics
  - Community-based ethics
  - Gender-sensitive ethics
- A brief history of Bioethics
- Basic bioethics principles
A Working Definition of Ethics

“Ethics is a code of values which guide our choices and actions and determines the purpose and course of our lives.”

Ayn Rand, Russian-American novelist and philosopher (1905-1982)
Ethical Theories Underlying Bioethics

Ethical theories usually utilized in bioethics have competing, and partially overlapping frameworks:

- Theories that focusing on the development of individual character (Virtue Ethics).
- Theories based on the idea that what is right, is what will bring the most happiness to the most people (Utilitarianism).
- Theories that are rule-based and proceed from the idea that people have a “duty” to do certain things (Deontology).
- Ethical systems which focus on the inter-relationship of society and the groups and individuals within it. (Communitarianism, Feminist ethics).
Virtue Ethics

- Origins date primarily to Aristotle in his landmark work "Nicomachean Ethics" (350 BC).
- Focuses on the development of moral character through right habits.
- One difficulty with virtue ethics: Different people, cultures and societies often have vastly different opinions on what constitutes a virtue.
- Virtue ethics does not focus on what sorts of actions are morally permitted and which ones are not, but rather on what sort of qualities someone ought to foster in order to become a good person.
Utilitarianism – History

- Utilitarianism first proposed by the Chinese philosopher Mozi between 479-381 B.C.

- During the 1800’s utilitarianism championed by Jeremy Bentham who is credited with "the greatest happiness principle," - referred to as the principle of utility.

- Utilitarianism revised and expanded by Bentham's student, John Stuart Mill In his famous book, Utilitarianism (1861).
Utilitarianism

An action is right if and only if it achieves the greatest good for the greatest number.

Utilitarianism makes moral judgments based on the consequences of actions. In making choices we must consider the cost for everyone.

Utilitarians believe the purpose of morality is to make the world a better place.

Most public health policies are based on this theory.
Utilitarianism – Strengths & Weaknesses

Strengths
- Captures the common sense intuition that consequences matter
- Seems relatively simple, empirically based solution to moral problems
- Impartial and egalitarian approach

Weaknesses
- Questionable theory of value
- Assessment about whether a particular act will maximize happiness is difficult
- Conflicts with some of basic moral intuitions about rights and justice
Deontology

- Immanuel Kant (1724-1804) is credited as laying the foundations of deontology.

- Kant theorized that moral obligations rested solely on duty and not consequences of particular actions.

- According to Kant, several important principals help us determine what our moral duties are. We should:
  - Act only on that maxim through which you can at the same time will that it become a universal law.”
  - "Act in such a way that you always treat humanity never merely as a means but always at the same time as an end-in-itself.”
Kant defined several types of imperatives:

- **Categorical imperatives** are required in all circumstances and are justified as ends in themselves. The provision of Individual human rights, for example, is a categorical imperative.

- **Hypothetical imperatives** are those whose justification depends on the perceived good of something extrinsic to themselves. (ie. “If you want good business don't cheat your customers”)

ver may07
Deontology - Duties

- Kant emphasized that duty comes first, and rights are the correlate of duties. All statements about rights can be translated into statements about duties.

- For Kant, there were two obvious types of duties:
  - **Perfect duties** were those that we must always observe such as "Never lie," or "Never kill."
  - **Imperfect duties** were positive obligations such as giving to charity. These actions can only be observed by those capable of doing so.
Deontology – Strengths and Weaknesses

Strengths
- Consistency and universality
- Foundation for “common sense” rules of morality
- Provides a rationale for individual rights

Weaknesses
- No moral role for consequences
- No guidance on how to resolve conflicts between and among perfect duties
Communitarianism emphasizes social connectedness, and sees individuals as members of a community, embedded in community norms and history, and not as...atomized individuals…”

Communitarianism

- In the 1980’s social and political theorists such as Charles Taylor, Michael Sandel, Michael Walzer and Amitai Etzioni formulated communitarian principles.

- Central to many communitarians' philosophy is the concept of positive rights; that is, rights or guarantees of certain things. They include such things as a free education, affordable housing, a safe and clean environment, universal health care, or even the right to a job.
Communitarianism, contd.

- Communitarians take issue with the idea that individuals should stand in an unmediated relationship with the state and society.

- Communitarians also promote the value of community and tradition. They argue that what is important cannot be universalized, that will depend upon the traditions and ways of life in a particular society.
Communitarianism – Strengths and Weaknesses

Strengths

- Encourages the protection of diverse traditions and cultures.
- Promotes engagement with key stakeholders in ethical decisions.

Weaknesses

- The provision of positive rights for some may be a violation of rights for others.
- Communitarianism doesn’t provide guidance for moral concerns that bridge societies.
Feminist Ethics, contd.

- Proponents of feminist approaches to ethics believe traditional western moral theories ignore, trivialize, or demean those traits of personality and virtues of character that are culturally associated with women.

- Much of feminist ethical theory revolves around the “ethics of care -- that we should cultivate our natural capacity to care for others and ourselves.
Feminist Ethics, contd.

- Focuses on actions, the outcomes of actions and the nature of agents.
- Consequences morally relevant but not exclusively so
- Persons intrinsically valuable
- Social justice is an overriding concern
Bioethics

The study of the moral questions raised by research on living beings and the applications of that research.
Brief History of Bioethics

- (1947) The Nuremberg Code – The tribunal at Nuremberg laid down 10 standards to which physicians must conform when carrying out experiments on human participants in reaction to gross abuses in human experimentation performed in Nazi Germany.

- (1964) Declaration of Helsinki was issued by the World Medical Association establishing recommendations to guide medical doctors in biomedical research involving human participants.
Brief History of Bioethics, contd.

- (1974) The U.S. National Research Act was passed in response to disclosures about the Tuskegee Syphilis Study. It created the National Commission for the Protection of Human participants of Biomedical and Behavioral Research.

Basic Bioethics Principles

The Belmont report outlines 3 principles for research on human participants:

1. **Respect for Persons**: This principle incorporates at least two ethical convictions: first, that individuals should be treated as autonomous agents, and second, that persons with diminished autonomy are entitled to protection.
Basic Bioethics Principles

2. Beneficence and Nonmalificence: Research participants must be treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being.

3. Justice: The burdens and benefits of research should be distributed fairly.
Discussion

- There is an outbreak of an unknown infectious disease in the small Republic of Slabovia. The Prime Minister consults with her public health officials to decide whether quarantine of suspected carriers and compulsory vaccination is justified. Among her officials, one is a utilitarian, one believes in deontology, and the third is a communitarian.

- What arguments will they make for or against the policy? On what basis should the Prime Minister make her decision?
Module 2
Informed Consent

By the end of the day the participants should be able to:

- Understand the meaning of “informed consent.”
- Appreciate the challenges of implementing “informed consent” in research settings.
- Be aware of the ways researchers respond to these challenges.

Preparatory Readings:


Handouts:

- Case study: Adolescents
- Case study: Community Consent

Training Schedule:

Time: 1 hour 30 minutes (45 minutes for case studies and 45 minutes for presentation and discussion)

Facilitator Notes:

Case Study: Divide the class up into two groups and have them read and discuss the first study (20 minutes).

Presentation (45 minutes):

Slide 1: Module Title

Slide 2: Module Objectives

Slide 3: What is ‘informed consent’?

Two more definitions of ‘informed consent’:

- The Belmont Report defined informed consent in the following way: “Respect for persons requires that participants, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them. This opportunity is provided, when adequate standards for informed consent are satisfied. While the importance of informed consent is unquestioned, controversy prevails over the nature and possibility of an informed consent. Nonetheless, there is widespread
agreement that the consent process can be analyzed as containing three elements: information, comprehension and voluntariness.”

- In the Nuremburg Code ‘informed consent’ is defined as “agreement with full information of a person with competence and capacity, made without force, fraud, deceit, duress, coercion or undue influence.”

- In its Helsinki Declaration, the World Medical Association defined ‘informed consent’ in research as a process where “each participant must be adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail.”

Slide Four: Elements of ‘informed consent’

The goal of ‘informed consent’ is making sure a participant has the opportunity to be an informed participant in decisions affecting their welfare.

Basic elements of ‘informed consent’

- Disclosure: It is generally accepted that ‘informed consent’ includes a discussion of:
  - the nature of the decision/procedure;
  - reasonable alternatives;
  - relevant risks, benefits, and uncertainties related to the research.

- Voluntariness: In order for the patient's consent to be valid, consent must be voluntary and free of coercion.

- Comprehension: The participant must be competent to make the decision and the discussion should be carried on in layperson's terms with the participant’s understanding assessed along the way.

- Documentation: Many Institutional Review Boards (IRB) have developed standard language and/or a standard format to be used in portions of all consent documents. Standard language is typically developed for those elements that deal with confidentiality, compensation, answers to questions, and the voluntary nature of participation.

Slide Five: Disclosure

- Research Purpose: Investigators must give a fair explanation of how findings from the research will be used.

- Study Procedures: Tasks and procedures must be explained from the participant's point of view and the total time investment should be specified. The criteria for participation should also be described.

- Risks: Describe any foreseeable risks or discomforts the participant will bear. Risks may range from inconvenience to bodily pain. “Soft" risks such as confidentiality and embarrassment should
not be overlooked. Since invasive procedures will always involve a degree of uncertainty
investigators should describe the probability that these situations may occur.

- Benefits: Investigators should describe any benefits to the participant including monetary
  compensation.

- Alternatives: Participants should be told if there are alternative procedures or options. In
  nontherapeutic studies, the alternative may simply be nonparticipation.

- Confidentiality: The ‘informed consent’ process must describe the level of confidentiality of the
  research data and the measures that you plan to take to ensure that confidentiality is maintained. 
  However, in special circumstances, such as for reportable conditions like child abuse, absolute
  confidentiality may not be possible. If this or a similar possibility exists, then investigators should
  explain the circumstances under which information must be disclosed and to whom.

- Conflict of Interest: Researchers must inform their participants of any conflicts of interest they
  have in the research, such as a stake in a company that might benefit from the research.

- Withdrawal: Participants must be told that participation is voluntary and that refusing to
  participate will involve no penalty or decrease in benefits to which the participant is otherwise
  entitled. Participants should also be told that they can discontinue participation at any time.

**Slide Six:** Challenges to disclosure

*Finding the right way to describe the research*

Time, staffing limitations, and the ability to judge potential participants' comprehension may be difficult. Cultural differences, language barriers, homelessness, psychiatric illness, alcohol or drug addiction, and the effects of age all may play a part in determining whether the potential participant understands the risks and benefits of the research.

*Recruiting appropriate participants and providing adequate time and a suitable setting that will promote comprehension.*

- Careful selection of research participants is necessary to avoid recruiting people simply because of
  their easy availability, their compromised position, or their manipulability, rather than for reasons
  directly related to the problem being studied.

- The way that information is conveyed is as important as the information itself. Disclosing in a
  disorganized or rapid fashion, allowing too little time for consideration or curtailing opportunities
  for questioning, may adversely affect a participant's ability to make an informed choice.

- Some settings, such as prisons, or hospital casualty wards, may be inherently coercive. Careful
  consideration should be given to whether they are appropriate for gaining ‘informed consent’.

**Slide Seven:** Responses to disclosure challenges

*Describe research in terms potential participants can understand.*
Providing examples that describe common problems facing a community or individual promotes comprehension.

*Have a trusted individual or organization provide the information.*

Where appropriate, having local leadership or organizations representing or working in the interests of potential participants, provide information about the research will increase the understanding and comprehension of potential participants.

*Time disclosure appropriately*

Strike a balance between providing information close to enrollment but provide time to deliberate.

*Provide information in a safe, comfortable setting.*

Institutional settings may inherently limit the freedoms of individuals and may generate significant pressures on individuals, especially prisoners, nursing home residents, or mentally or physically ill people. Consent should be gained in an appropriate locale where a potential participants feel free to refuse to participate.

**Slide 8: Comprehension**

Researchers have an obligation to attempt to gain sufficient comprehension of the information to enable a potential participant to make an informed decision about whether to participate in a study. They should not set the standard of understanding so high that they violate the principle of justice by denying participation to some people and not others. The higher the potential risks of participation, the higher the threshold for comprehension should be.

**Slide 9: Enhancing comprehension: a question of how to disclose**

A systematic review of research studies on improving participant comprehension in ‘informed consent’ found that the following strategies were useful:

“More highly structured and more uniform consent processes, better organized, shorter and more readable consent forms, and simplified and illustrated formats all improved patients' understanding. Corrected feedback, multiple learning trials, "advance organizers" (which alert patients to information about to be presented), and summaries of information also enhanced understanding. Highly detailed information, however, was not consistently associated with better understanding. Augmenting or replacing the consent form (e.g., with a videotape) showed some promise, but these studies were limited in number, and results were inconsistent.”

*Laura B Dunn1, Dilip V Jeste, Enhancing ‘informed consent’ for Research and Treatment Neuropsychopharmacology (2001) 24 595-607.10.1038/sj.npp.1395626*

**Slide 10: Examples of enhancing comprehension**


   - A randomized, double-blind, controlled trial of the relative efficacy of a diphtheria-tetanus-acellular-pertussis vaccine and a whole-cell diphtheria-tetanus-pertussis vaccine in rural Senegal Ver may07
• Challenge: To “explain the principle of randomization and the possibility that one of the vaccines might fail.”

• Response: Use a “familiar agricultural example - the evaluation of fertilizers or of seed varieties on randomized plots, a procedure familiar to farmers in the area.”

Source: Preziosi, Marie-Pierre; Yam, Ablaye; Ndiaye, Malick; Simaga, Aminata; Simondon, Francois; Wassilak, Steven G.F. Practical Experiences in Obtaining ‘informed consent’ for a Vaccine Trial in Rural Africa.

2. Study on voluntary counseling and testing for HIV in Maharashtra.

• Study context: voluntary counseling and testing for HIV among pregnant women attending an antenatal clinic in Maharashtra.

• Challenge: promoting women’s understanding of HIV/AIDS testing so that they could make an informed decision

• Methods: Provided group education and counseling (GEC) – Standard; Added “culturally appropriate visual aids” to GEC - (GEC+); Reinforced visuals during individual counseling.


3. Use of visual aids in group education and counseling (GEC) in an antenatal clinic in Pune

A study was conducted in Pune, Maharashtra, to determine if using visual aids during the group education and counseling (GEC) sessions would enhance comprehension. The results showed comprehension of:

• Benefits of HIV Testing increased from 29% to 39%
• Consequences of refusal to test increased from 19% to 75%
• Right to refuse increased from 54% to 79%
• Overall understanding went from 38% to 72%


Slide 11: How can comprehension be assessed?

Corrected feedback during consent sessions.

Studies have found that the use of “corrected feedback” provided a significant general improvement at all vocabulary levels.

Formal tests.

Researchers use a variety of different methods for measuring comprehension including true-false questions, multiple choice questions, and asking participants to paraphrase documents.

Independent monitoring.

When reviewing greater than minimal risk research involving individuals with questionable capacity to consent, investigators should consider appointing an independent monitor to observe recruitment, assessment, the ‘informed consent’ process, and debriefing of research participants.

Slide 12: Voluntariness

The Belmont Report defines “voluntariness” as “an agreement to participate in research… voluntarily given. This element of ‘informed consent’ requires conditions free of coercion and undue influence. Coercion occurs when an overt threat of harm is intentionally presented by one person to another in order to obtain compliance. Undue influence, by contrast, occurs through an offer of an excessive, unwarranted, inappropriate or improper reward or other overture in order to obtain compliance. Also, inducements that would ordinarily be acceptable may become undue influences if the participant is especially vulnerable.

Unjustifiable pressures usually occur when persons in positions of authority or commanding influence --- especially where possible sanctions are involved - urge a course of action for a participant. A continuum of such influencing factors exists, however, and it is impossible to state precisely where justifiable persuasion ends and undue influence begins. But undue influence would include actions such as manipulating a person's choice through the controlling influence of a close relative and threatening to withdraw health services to which an individual would otherwise be entitled. “

“The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Participants of Research”, The National Commission for the Protection of Human Participants of Biomedical and Behavioral Research

Slide 13: Challenges to “voluntariness”

Social inequalities & power dynamics.

- Gender inequalities

In some contexts, partners (e.g., spouses) may need to be involved in the consent process. According to the WHO: “A requirement of partner agreement or authorization for an individual to participate in research violates the autonomy of research participants and their right to confidentiality.”


According to the US National Bioethics Advisory Commission (NBAC), requiring spousal agreement is permissible only when: 1) it would be impossible to conduct the research without obtaining such supplemental permission; 2) failure to conduct this research could deny its potential benefits to women in the host country; and 3) measures to respect the woman’s autonomy to consent to research are undertaken to the greatest extent possible. (Source: NBAC. Chapter 3.)

Ver may07
Slide 14: Challenges to “voluntariness”, cont.

Role of Medicine in some societies:

Example: randomized controlled trial in Vietnam

Study: A randomized controlled trial of adjuvant surgical oophorectomy and tamoxifen among women with operable breast cancer.

Challenge: Western notions of ‘informed consent’ are inconsistent with … standard practice in Vietnam, but apparently preferred by the Vietnamese-people. … it is not customary in Vietnam for patients to participate in their own medical decisions in the way that is normative in the United States and other Western cultures.

Researcher’s response: 1) Two surrogate groups of laypersons who resemble potential participants, educated Vietnamese living in America and members of the Vietnamese Women’s Union, were recruited to provide input on protocols & ‘informed consent’ processes”; 2) Study protocols received expert peer review by Vietnamese and international physicians.

US IRB response: Written information including information on randomization was required. A small consent study of 13 participants for three months after enrollment was approved.


Slide 15: Challenges to “voluntariness”, cont.

Economic inequalities that produce undue inducement

“The offer of benefits in some contexts may amount to undue inducement, and thus negate the voluntary aspect of the consent of participants who may perceive such offers as a way to gain favour or improve their situation.” (Article 2.1(c) was adapted from U.S. Department of Health and Human Services, Protection of Human Participants, Title 45: “Code of Federal Regulations” Part 46.116(d).)

According to the National Bioethics Advisory Commission: “The potential benefit of receiving medical care that is difficult to access (but should be accessible) is not an undue inducement.”

Slide 16: Challenges to “voluntariness”, cont.

Community structures and dynamics

The Indian Council of Medical Research has set guidelines for community consent:

“Where any such research entails treating any community or group of persons as a research participant, these principles of voluntariness and ‘informed consent’ shall apply, mutatis mutandis, to the community as a whole and to each individual member who is the participant of the research or experiment.”

Ver may07
Ethical Guidelines for Biomedical Research on Human Participants
INDIAN COUNCIL OF MEDICAL RESEARCH NEW DELHI

Among the difficult questions this raises for researchers:

- How is “community” defined?
- How can we identify which leaders should provide consent?
- Are community leaders able to provide consent?
- What responsibility does a researcher have when “community consent” negates an individual’s right to refuse?

**Slide 17: Challenges to “voluntariness”, cont.**

*Family dynamics*

On the rights of minors and their parents and guardians:

The Declaration of Helsinki 2000 states: “If the minor is able to understand the research, his or her assent is necessary in addition to the consent of the parents.”

On the impact of family members on voluntariness in giving ‘informed consent’:

“The presence or absence of loved ones may affect the person’s process of clarifying and expressing choice. In sum, qualities of the environment, relationships, and the decisional process may all serve to add to or detract from the individual’s voluntarism in giving ‘informed consent’.”


**Slide 18: Challenges to “voluntariness”, cont.**

*Other factors: age, education/literacy*

The investigator must ensure that the circumstances under which consent is sought will provide the participant (or his/her representative) with sufficient opportunity to consider whether or not to participate. The circumstances must also minimize the possibility of coercion or undue influence that might be experienced by the participants. Often the situation may be inherently coercive; i.e., their freedom of choice may be restricted by their age, associations with certain groups, or their mental or physical capacities.

Low literacy may also impair functioning in the research environment, affect communication dynamics, and inadvertently lead to “uninformed consent”. It is associated with poor understanding of written or spoken communications, and poor outcomes in healthcare.

**Slide 19: How to assess “voluntariness”**

*Consent monitoring*
Methods for ensuring that ‘informed consent’ is made with “voluntariness” is the responsibility of investigators. They can use informal or informal methods to ensure that protocols for consent are properly administered.

Slide 20: Documentation

Whenever you intend to collect research data directly from research participants you will need the written consent of each individual for use of their personal data in your research. Talking or writing to the research participants to inform them of what you intend to do, and inviting them to contact you if they object, is NOT sufficient. A non-response will not signify that you have the fully informed and freely given consent of that person.

The research participants must indicate that they understand what will happen and why and that they agree to the use of their data for your purposes. You must have records to show that this was the case.

ICMR, 2000: “Written ‘informed consent’, preferably witnessed by a person unconnected with the study, should be obtained as a general rule.”

Slide 21: Documentation: challenges

Situations where getting signed consent may be inappropriate:

- When conducting research on sensitive issues and obtaining signatures (or thumbprints) may jeopardize confidentiality. [Ethical problem]
- When potential participants are reluctant to sign (and the protocol requires this), resulting in a biased sample. [Methodological problem]

Slide 22: Why document consent?

“The goal of the ‘informed consent’ process is to provide people with sufficient information so they can make informed choices about whether to begin or continue participation in clinical research. The process involves a dynamic and continuing exchange of information between the research team and the participant throughout the research experience. It includes discussion of the study's purpose, research procedures, risks and potential benefits, and the voluntary nature of participation.

The ‘informed consent’ document provides a summary of the clinical study and the individual's rights as a research participant. The document acts as a starting point for the necessary exchange of information between the investigator and potential research participant. Also, research participants and their families may use the consent document as an information resource and reference throughout participation in the trial.

The ‘informed consent’ document is often considered the foundation of the ‘informed consent’ process; it does not, however, represent the entirety of the process. Nor is the ‘informed consent’ document a risk-management tool for the investigator and/or institution.”

National Cancer Institute (NCI), Office of Human Research Protections and the U.S. Food and Drug Administration ‘informed consent’ Working Group

Ver may07
The ‘informed consent’ document is only one part of the larger process of ‘informed consent’ that occurs between the potential research participant and members of the research team.

“The ‘informed consent’ process should involve an ongoing dialogue between investigators and research participants. Investigators should address the research participants' concerns and questions and should confirm that research participants understand the basic purpose and conduct of the study. Only in this way can researchers ensure that the rights of research participants are protected and that the integrity of the ‘informed consent’ process is maintained.”

National Cancer Institute (NCI), Office of Human Research Protections and the U.S. Food and Drug Administration ‘informed consent’ Working Group

The Common Rule clearly allows IRBs to authorize oral ‘informed consent’. Section 46.117(c) of the regulations permits the waiver of written consent, either if the consent document would be the only form linking the participant and the research and if the risk of harm would derive from the breach of confidentiality or if the research is of minimal risk and signing a consent document would be culturally inappropriate in that context. Section 46.116(d) authorizes the IRB to waive ‘informed consent’ or approve a consent procedure that alters or eliminates some or all of the elements of ‘informed consent’ if four conditions are met: (1) the research is of no more than minimal risk; (2) the change in consent procedures will not harm the respondents; (3) the research could not "practically be carried out without the waiver or alteration; " and (4) whenever appropriate, additional information will be provided to participants after participation.

Research in the following areas are excepted from human research protections:

- Educational settings involving normal educational practices: Testing new curricula, teaching methods, etc.

- When data are recorded without any identifiers/links and disclosure of responses would not place participants at risk for any social, economic, psychological harm

- When research involves use of existing data, documents, records, specimens, if publicly available or if the information is unlinked.

Case Study: Divide the class up into two groups and have them read and discuss the second case study (20 minutes).
Adolescents: Autonomy, Culture and Legalities

An NGO conducts a study of reproductive and sexual health among married adolescent girls in the urban slums of Bangalore. The goal of the study is to evaluate a reproductive and sexual health counseling intervention. Five hundred married adolescent girls will be randomly assigned to an intervention group (which will receive 6 counseling sessions over 6 months) or to a control group (which will receive 6 nutritional education sessions over 6 months). The girls will be followed for 12 months and their use of different contraceptive methods (including the male condom, the contraceptive pill, the IUD and sterilization) will be evaluated.

The research team consists of women in their early 20s, married and unmarried, who are living in similar communities. Married adolescent girls ranging in age from 15 to 21 years will be recruited. Prior qualitative research in these areas indicated that many of potential participants live with one or both parents-in-law and have one or more children.

Although a large proportion of potential participants are minors (below 18 years) and therefore not legally competent to consent, the researchers decide that married, sexually active, women who have household responsibilities, including bearing and raising children, are competent to give written consent for participating in this study.

In one household, the husband of a married adolescent girl interrupted the informed consent discussion. The girl had just signed the consent form when her husband returned. He asks what is going on, and the research interviewer informs him about the purpose of her visit. He sees the signed consent form, and becomes enraged that his wife has signed it without discussing it with him. He turns to his wife and gives her a slap. The interviewer tries to intervene but he orders her to leave the house. The interviewer is shaken, and leaves to report the incident to her supervisor.

When the interviewer and supervisor return to the area the next day, they are stopped by a local policeman. He tells them to stop the research as a local politician has threatened to file a complaint on the grounds that medical procedures are going to be conducted on minor girls without consent from their guardians – parents in law or husband.

Questions

1. Do you agree with the researchers’ reasoning regarding from whom to obtain consent? Why or why not?

2. When do you think written documentation of consent is necessary? Was it warranted in this situation?

3. Describe steps that the researchers could have taken to avoid such an incident.
Module 2: Informed Consent
Case Study 2

Respect, autonomy and community consent

A public health post-graduate student decided to conduct a study on the prevalence of a vector-borne disease in an isolated Indian tribal population that was thought to have high morbidity and mortality as a result of this infection. Participants are required to provide three drops of blood through the finger prick method. In addition, medical histories and other information is gathered through individual interviews. Systematic random sampling was used to select study participants.

The researcher considered the following options for obtaining and documenting informed consent:

- Written consent using an informed consent form: this option was rejected since the community was largely illiterate. Further, community members viewed signatures and thumbprints with suspicion as they associated them with giving away land rights or signing promissory notes.

- Verbal consent documented by audio recording: this option appealed to the researcher but tape recorders could not be accommodated in the budget.

- Consent from community leaders: this option was appealing because it was in keeping with how the community normally functions. In contrast to ‘modern’ values that emphasize individual autonomy, tribal communities emphasize collective decision-making, that is, decision-making by community representatives or leaders.

- The researcher decided to choose this option – to explain the study to community leaders, who would decide whether their community would participate or not. The leaders would communicate their decision to potential participants.

Questions:

1. Do you think the researcher’s selection of consent from community leaders is appropriate?
   1. List other options.

2. Do you think there is a difference between ‘obtaining’ and ‘documenting’ informed consent? Please explain/elaborate.

3. Do you think it is appropriate to emphasize respect and autonomy of individuals in a cultural context that is not premised on ‘individualism’? That is, should researchers tamper with the value system of communities to meet their own requirements? Why or why not?
Module 2: Informed Consent  
Case Study 3

Deception, Data Validity and Ethics

A group of social scientists are conducting research on the impact of stigma on access to health care among people living with HIV/AIDS (PLHAs) in an urban setting. They decide to use multiple methods to explore this issue, including in-depth interviews with PLHAs and a survey of a sample of health care workers (doctors, nurses, etc) in private and public clinics and hospitals in large and small urban settings in an Indian state.

A reviewer of their proposal notes that given increasing awareness about HIV/AIDS including the activities of networks of positive people in a number of these cities and towns, health care workers may tend to provide ‘politically correct’ answers to the questionnaire. That is, health care workers may tend to report fewer discriminatory practices than are truly present. Therefore, the reviewer recommends that the researchers collect additional qualitative data through mystery client interviews to validate the quantitative data. In mystery client (or simulated patient) interviews, research staff would approach selected health care workers posing as PLHAs seeking medical care. They would follow a pre-determined script and after the ‘interview’ record their experiences.

The researchers are trying to prepare their protocol for submission to their institutional ethics committee, and have to come up with answers to the following questions:

1. Do you think mystery client interviews are warranted in this situation? Why or why not?
2. In this case, is it possible to obtain informed consent from the ‘participating’ health care workers? List reasons for why or why not.
3. What are the researchers’ obligations to disclose information to the health care workers – either before or after the data collection?
4. What potential harms to the participants or researchers may be anticipated?
5. Have the researchers adequately considered all available options for gathering the data?

Source: Samuha-UCSF Fogarty Ethics Training Project
Informed Consent

Basic training on ethical issues in health research

Module 2
Module Objectives

By the end of this module participants should:

- Understand the meaning of ‘informed consent’.
- Appreciate the challenges of implementing 'informed consent' in research settings.
- Be aware of the ways researchers respond to these challenges.
What is ‘Informed Consent’?

- Participants should “be given the opportunity to choose what shall or shall not happen to them.”

The Belmont Report
The goal of ‘informed consent’ is to make sure an individual has the opportunity to be an informed participant in decisions affecting their welfare.
Disclosure

Investigators must provide information about:

- Research purpose
- Study procedures
- Risks & Benefits
- Alternatives
- Confidentiality
- Potential conflicts of interest
- Information about withdrawal
Challenges to Disclosure

- Finding the right way to describe the research.
- Recruiting appropriate participants and providing adequate time and a setting that will promote comprehension.
Responses to Disclosure Challenges

- Describe research in terms potential participants understand.
- Have a trusted individual or organization help provide information.
- Time disclosure appropriately.
- Disclose in a safe, comfortable setting.
- Pilot informed consent procedures.
Comprehension

- Comprehension is required for ‘informed consent’. It may be limited by language, culture, education level, literacy, mental and emotional state, age of the volunteer, and other factors.
Enhancing Comprehension: A Question of How to Disclose

Comprehension can be enhanced with use of:

- Cultural and community appropriate examples and metaphors.
- Visual flipcharts and posters that utilize bold colors and convey only one message each.
- Well organized, short, and readable consent forms illustrated for people with limited literacy.
Examples of Enhancing Comprehension

- Clinical trial in Senegal on diphtheria-tetanus-acellular-pertussis vaccine.

- Use of visual aids to improve group education and counseling (GEC) in an antenatal clinic in Pune, India.
How Can Comprehension Be Assessed?

- Corrected feedback during consent sessions.
- Formal tests.
- Independent monitoring.
Voluntariness

‘Informed consent’ “must be free of coercion and undue influence.”

The Belmont Report
Challenges to “Voluntariness”

- Gender inequalities & power dynamics

Example from rural India:

Question: Who would decide whether you participate in a study or not?

<table>
<thead>
<tr>
<th></th>
<th>THEMSELVES</th>
<th>SPOUSE</th>
<th>OTHER</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>45 (90%)</td>
<td>--</td>
<td>5</td>
<td>50</td>
</tr>
<tr>
<td>Women</td>
<td>3 (43%)</td>
<td>2</td>
<td>2</td>
<td>7</td>
</tr>
</tbody>
</table>

Challenges to “Voluntariness”, contd.

- Role of medicine in society

In some contexts, medical professionals are expected to make decisions for their patients.

- Example: randomized controlled trial in Vietnam
Challenges to “Voluntariness”, contd.

- Economic inequalities that produce undue inducement
  - Will the study offer medical care, payment or other benefits that may not be otherwise available or that are enhanced in order to promote participation?
Challenges to “Voluntariness”, contd.

Community structures and dynamics

“In some settings, the internationally agreed upon standard for individual informed consent that derives from the norm of autonomy can seem inappropriate since important decisions are often made in conjunction with families or by entire communities.”

European Group on Ethics in Science and New Technologies to the European Commission
Challenges to “Voluntariness”, contd.

- Family dynamics
  - Researchers are required to obtain “assent” from minors even in the case where parents have given their informed consent for a child’s participation in research.
  - Family dynamics can enhance or detract from “voluntariness”.

ver may07
Challenges to “Voluntariness”, contd.

- Other factors: age, education/literacy

Freedom of choice may be restricted by age, literacy, mental capacity, etc.

How to Assess Voluntariness

- Consent monitoring
  - Informal
    - Make “voluntariness” a regular topic in project meetings and problem-solve.
  - Formal
    - Administer a self-monitoring questionnaire to participants to evaluate the informed consent process.
    - Appoint a Monitor to observe and report observations on the informed consent process.
Written informed consent, preferably witnessed by a person unconnected with the study, should be obtained “as a general rule.”

ICMR, 2000
Documentation: Challenges

- In many situations, written consent may be inappropriate.
Why Document Consent?

- The informed consent document provides a summary of the study and the individual's rights as a research participant.
- It provides documentation of the ‘informed consent’ process.
- Investigators can use it to assess whether there is non-response bias in the sample.
The informed consent document is only one part of the larger process that occurs between the potential research participant and members of the research team.
The US Department of Health and Human Services’ Common Rule, which guides US government-funded research, clearly allows IRBs to authorize oral informed consent under certain conditions.
Exemptions to Human Research Protections

- In educational settings.
- When data are recorded without any identifiers/links.
- With existing data if “unlinked.”
Thank you!
Module 3
Privacy and Confidentiality

Objectives:

By the end of the day the participants should be able to:

- Be familiar with the concepts of “privacy” and “confidentiality” and their application in research ethics.
- Understand ethics guidelines on “privacy” and “confidentiality.”
- Appreciate the challenges to “privacy” and “confidentiality.”
- Understand legal recourse and protections afforded to study participants, and the obligations required of researchers.

Preparatory Readings:

Universal Declaration of Human Rights (1948)
International Covenant on Civil and Political Rights (1966)
International Covenant on Economic, Social, and Cultural Rights (1966)
Convention on the Elimination of all Forms of Discrimination Against Women (1979)

Handouts:

- Case study 1: Publishing research findings
- Case study 2: Working with vulnerable populations

Training Schedule:

Time: 1 hour 30 minutes (45 minutes for case studies and 45 minutes for presentation and discussion)

Facilitator Notes:

Case Study: Divide the class up into two groups and have them read and discuss the first study (20 minutes).

Presentation (45 minutes):

Slide One: Module Title

Slide Two: “What is Privacy and Confidentiality?”

Because the right to privacy cannot be respected unless confidentiality is observed, the two concepts are often coupled and thought of as a single right: "the right to confidentiality and privacy".

The two ideas however, are not the same. The World Health Organization (WHO) defines privacy as “personal right” and confidentiality as a “duty”.

Slide Three: Overview of Module Objectives

Slide Four: Activity: Brainstorming session on the meaning of “privacy”.

Ver may07
Slide Five: “The Concept of Privacy”

Although they might not be able to express a concise definition of the concept, everyone is sensitive to having their privacy violated. The concepts of "personal matters" and "intimate knowledge" are familiar, as is the notion that individuals live in a "private sphere" over which they are to be granted autonomy. The right to a private life was proclaimed in the Universal Declaration of Human Rights and has been reaffirmed in every other human rights declaration since 1945.

Privacy Definitions:

- The World Health Organization definition of “privacy” is "the right and power to control the information (about oneself) that others possess” (2000b).
- The U.S. Office of Protection from Research Risks defines privacy in terms of having control over the extent, timing, and circumstances of sharing oneself (physically, behaviorally, or intellectually) with others.

How should a participant’s privacy be protected in a research setting?

Research participants have a right to keep information about behavior occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, private. That information is provided to an investigator for specific purposes and the participant should reasonably expect that it will not be made public. Private information must be individually identifiable in order for obtaining the information to constitute research involving human participants (Federal regulations governing human research (45 CFR 46.102 (f))

What limits a person’s ability to control access to private information?

A person’s ability to control access to their personal information is determined by a variety of factors. They include socioeconomic status, age, and circumstance. For example, information about welfare rolls is public information; information about personal stock portfolios is not unless you are a government official. Minors have fewer rights to privacy, than adults. Institutionalized persons may have significant limitations on their ability to control personal information.

Slide Six: Importance of Privacy

Privacy is valued because respecting privacy in turn respects the autonomy of persons, protects against surveillance or intrusion, and allows individuals to control the dissemination and use of information about themselves. Privacy fosters and enhances a sense of self and also promotes the development of character traits and close relationships (IOM, 1994)

Loss of privacy can have important personal and social dimensions.

Examples:
- Potential participants may be unwilling to seek health treatment, including voluntary testing for HIV/AIDS, because they fear that the services are not confidential.
• Wives may be physically or verbally abused by family members for participating in research.

• Women may fear that stigma might diminish their opportunities for marriage, or that a positive test result might lead to job loss, ridicule, retribution, or abandonment by spouses, parents, families, friends, community members, or religious leaders.

• Infants may become infected with HIV because HIV-positive mothers fear to be tested or are unwilling to undergo treatment to prevent parent-to-child transmission.

Protection of privacy enhances research

• Participants are more likely to provide accurate and complete information if they have confidence in research staff. In the absence of accurate information, research is compromised and participants will not receive proper treatment or advice.

• Adolescents and other vulnerable groups are less likely to seek services or participate in research if they feel their privacy is will not be ensured. Fear that services will not be confidential is the number one reason adolescents give for not participating in reproductive health research.

Slide Seven: “Context-specific Challenges with Privacy”

The definition of “private information” may be governed by the culture of participants

In some cultures the name of a person who has passed away is extremely sensitive information. In these settings, it is important that close relatives are not asked to discuss, write down, or see written down, the name of a person who has died. Every society defines what information falls into the “private sphere” differently, so it is important that researchers understand the community in which they are working.

The definition of what is private is culturally dependent so investigators should

Power relationships may compromise a participant’s ability to control private information.

Research involving persons in dependent or unequal relationships such as teacher/student and doctor/patient may compromise a participant’s ability to give consent free from any form of pressure (real or implied) arising from this unequal power relationship.

“Gatekeepers” may have an impact on participant privacy

In some situations access to a research setting is gained via a 'gatekeeper' such as an employer or government agency. In these situations researchers should always gain informed consent directly from the research participants, while at the same time taking account of the gatekeepers' interest. Since the relationship between the research participant and the gatekeeper will continue long after the researcher has left the research setting, care should be taken not to inadvertently disturb that relationship.

Vulnerable groups need additional privacy safeguards.

Ver may07
The Indian Council on Medical Research defines "vulnerable groups" as those with diminished autonomy such as children, pregnant and lactating women, and prisoners.

**Resource constraints and inadequate scientific competencies can jeopardize the privacy of participants.**

It is the responsibility of researchers to ensure adequate protections for research participants. To design and conduct studies with inadequate resources and scientific skills may be considered unethical (European Epidemiology Federation).

**Slide Eight: Addressing Context-sensitive Challenges to Privacy**

**Researchers should:**

**Understand the community to be studied.**

They should:
- Be aware of community values and seek to operationalize those values in research design.
- Understand the determinants of wellbeing for participants including socioeconomic factors, power imbalances, loss of culture and traditional ways of living.
- Be familiar with the local language, history and legacy of previous research efforts in the community.

**Invest in training and sensitization for staff and community leaders.**

A well thought-out research plan should include training for both staff and community members involved in the research. Such a plan should include:
- Skill trainings utilizing outside resources including members of the community being studied.
- Other training resources including websites and discussion groups.
- Toolkits, presentations and articles that illuminate the culture and challenges facing the local community.

**Allocate adequate resources for project implementation.**

Investigators conducting human participant research must allocate adequate resources to insure the protection of human research participants.

**Seek expert advice.**

There are a growing number of training resources and professional organizations devoted to providing a platform for discourse on bioethical issues in India. These include but are not limited to Centre for Public Policy, Indian Institute of Management, the Indian Journal of Medical Ethics (IJME), the All India Association of Bioethics (AIBA), and the Fogarty International Center (FIC).

**Slide Nine: Ensuring Privacy Protections in Research**
Protection of participant privacy should be an integral part of research planning.

Every approach to a participant poses a risk for compromising participant privacy.

A major tenant for the protection of human participants is that persons can be wronged even if they are not harmed. Privacy is itself a form of personal protection. So, a violation of an individual’s privacy not only is a harm in itself, but also may cause the loss of this protective barrier. Risks include public exposure, perceived loss of control of person and a sense of insecurity. Breaches of privacy erode trust on all levels.

Investigators should also be aware that research may have possible effects on the daily life of participants. The demands of participation in studies can seriously disrupt the flow of normal activities. Researchers should design studies that take into consideration quality of life issues and they need to ensure that potential participants understand any potential impacts on their personal lifestyle.

“Creative” methods to ensure privacy can lead to other ethical problems

Creating privacy for participants using deceptive means may lead to other ethical problems. The use of “dummy” interviews for instance, may be an unsatisfactory strategy for several reasons. Having a group of interviewers conduct several simultaneous interviews may be intimidating to family groups. Misleading respondents who give their time to answer questions may also be a breach of trust.

Investigators have a responsibility to minimize deception whenever possible.

Slide Ten: “Confidentiality”

Slide Eleven: Activity: Brainstorming session on the meaning of “confidentiality”.

Slide Twelve: The Concept of Confidentiality

Two Definitions of “confidentiality”

1. Confidentiality is “the duty of those who receive private information not to disclose it without the patient’s consent” (WHO 2000b). Confidentiality is the means by which the privacy of a research participant is protected.

1. Confidentiality pertains to the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others in ways that are inconsistent with the understanding of the original disclosure without permission. (IRB Guidebook, Part III.D, Department of Health and Human Services, Office for Human Research Protections.)

Confidentiality arises from the consent process.

An investigator’s responsibility to protect the confidentiality of participants arises out of agreements made during the consent process. These agreements may include descriptions about whether or not identifiers will be retained, who will have access to identifiable data, and what methods will be used to safeguard data such as encrypted storage, locked files, and so on.

Ver may07
A breach of confidentiality may pose a serious risk to study participants.

Confidentiality is particularly important when participants are selected because of a sensitive, stigmatizing, or illegal characteristic. In these cases, a breach of confidentiality may pose a serious risk to study participants. A breach of confidentiality may damage reputations, jeopardize employment or insurance coverage, and even participant participants to domestic abuse or violence.

Maintaining confidentiality is critical to preserving the trust of the public in the research community.

Health research can offer many benefits including improved public health, better clinical practices, improved health products; advancements in basic biomedical science; and the development and improvement of pharmaceuticals and medical devices. All of this research, however, requires access to a great deal of data. This need for sensitive personal information often runs counter to the public's desire to keep health information confidential. Fear and anxiety over the loss of privacy and confidentiality may threaten research initiatives. Investigators, Institutional Review Boards (IRBs), and research institutions should work together to provide strong privacy and confidentiality protections in order to build public trust and encourage participation in research.

Investigators should consider confidentiality protection at all phases of research.

A sound data protection plan will include protocols for implementation, storage of data, publication, and data sharing with other researchers and institutions. Investigator should determine in advance whether personal identifiers are needed, how data will be de-identified when necessary, how sensitive information should be stored, the length of time data should be retained, and how it will be destroyed once it is not needed.

Roles, rights and obligations of sponsors, funders and employers with respect to confidential information, should be clarified in advance.

Investigators should be careful not to promise or imply acceptance of conditions which would be contrary to professional ethics or competing commitments. Where conflicts seem likely, sponsors or other interested parties should be referred to professional guidelines.

Restricted space for collection of sensitive information

A well planned research space should provide for both visual and auditory privacy.
• Visual privacy includes protection from unnecessary bodily exposure which may occur, for instance, during a physical examination. No one who is unnecessary to an interview or procedure should be allowed into the room without the explicit permission of the participant.

• Auditory privacy means that, to the extent possible, individual consultations should be conducted in private and out of earshot of others, including children, spouses, parents, family, friends, teachers, and neighbors.

**Cultural settings that limit individual privacy and autonomy.**

In many cultures, the family has a large role in health-seeking activities and clinical decision-making. This poses unique challenges for investigators seeking information about behaviors that are stigmatized, illegal, or may reflect badly on the reputation of the participant’s family. In India, women rarely attend healthcare facilities without a relative who may insist on being present in consultations or interview situations. It takes creativity and planning to ensure that the research setting will allow for privacy of participants without also generating suspicion among family members.

**Overlapping research roles.**

Investigators have the responsibility to safeguard confidentiality by minimizing access to personal information to those individuals who "need to know". Overlapping research roles often leads to greater access to sensitive information, posing a larger risk for breaches of confidentiality.

**Inadequate training of staff, outreach workers, and volunteers on issues surrounding privacy and confidentiality.**

Investigators should have a continuing training plan to educate staff, outreach workers, and volunteers, about library privacy and confidentiality principles, policies and procedures, and their legal and ethical responsibilities as custodians of personally identifiable information.

**Risk for breach of confidentiality of medical records in some health care settings**

An ethical issue may arise when third party health providers fail to adequately protect medical records for participants in research studies. Ethical practice requires investigator inform the participant of such a risk if it might reasonably be expected to influence willingness to participate or might pose a risk of harm to the participant.

**Slide Seventeen & Eighteen: Ensuring Confidentiality in Research-Recommendations**

1. Cultivate an atmosphere of respect for the privacy of the people being studied.
2. Collect identifiable data only if required for scientific reasons.
3. Ensure that participants give informed consent.
4. Safeguard personal identifiers as close to the point of original data collection as possible.
5. Enforce a policy of "No access to personally identifiable information" as the default— then base access on “need-to-know”.
6. Limit access to personally identifiable data. Maintain and monitor access "audit trails."

Ver may07
7. Remove data-participants' personal identifiability as thoroughly as is compatible with research needs. If key-coding, aggregating, or otherwise removing personally identifying information, do so with adequate rigor.
8. Maintain proper physical and computer safeguards.
9. Develop policies on seeking or allowing secondary use of personally identifiable data.
10. Sensitize, train, and certify all personnel who handle personally identifiable data.

Slide Nineteen: When are “privacy and confidentiality” protections NOT required?

In all research, investigators should be mindful of their responsibility to minimize harm and protect the dignity of human participants. Although information or behavior observed in the “public domain” traditionally are not accorded privacy protection, researchers should always submit protocols to an IRB or IEC before work begins.

Slide Twenty: “Striking a delicate balance”

Researchers must decide what personal information should be collected or stored, how individual privacy and confidentiality should be protected, and legitimate and legal demands for disclosures from individuals and groups. Investigators and Institutional Review Boards are charged with balancing the protection of participants with the needs of society for the data on which to base decisions about individual situations and formulate public policies.

Slide Twenty-one and Twenty-two: Indian Council of Medical Research Ethics guidelines (ICMR)

Excerpted sections:

Inclusion of requirements for “community consent” as well as individual consent

“In most epidemiological research it would be necessary to have the consent of the community which can be done through the Village Leaders, the Panchayat head, the tribal leaders etc.”

Less stringent standards for disclosure of sensitive information

"No details [should be released] about identity of said human participants, which would result in the disclosure of their identity, are disclosed without valid scientific and legal reasons which may be essential for the purposes of therapeutics or other interventions..."

Call for separate consent from participants of researcher publication plans

"It is recommended that a clear consent for publication shall be obtained besides the consent for participation in research or treatment and such a consent should preferable be obtained on two different occasions and not at the commencement of the study.”

Special individual protections in the area of genetic screening.

"Special privacy and confidentiality concerns arise in genetic family studies because of the relationship between the participants. It should be kept in mind that within families each person is an individual
who has the right to keep the information about himself or herself confidential. Family members are not entitled to know each other's diagnosis.”

**Anonymous genetic screening is permitted and under certain conditions, disclosure to individuals allowed.**

"Researchers may conduct anonymous testing on general population in order to establish prevalence of genetic traits/diseases...In the case information derived from stored specimens might be useful to an individual, the code of anonymity may be broken with the approval of the Institutional Ethics Committee (IEC)."

**Slide Twenty-three: NCESSRH Guidelines- Social Sciences**

Excerpted sections:

**The right whether to remain anonymous or to be identified lies with the participant.**

IV.3.1. Anonymity and confidentiality are the inherent of all participants. The right whether to remain anonymous or to be identified lies with the participant. It becomes all the more important in research projects dealing with stigmatized, sensitive or personal issues and information.

**Participant perspectives on privacy and confidentiality should be given adequate importance.**

IV.3.5. While deciding on what information should be regarded as private or confidential, the perspective of the participant(s) on the matter should also be given adequate importance.

**Researchers should identify possible breaches of confidentiality and anonymity addressing them prior to research.**

IV.3.2. Possibility of the breach of confidentiality and anonymity should be anticipated, addressed and explained to the participants.

**Slide Twenty-four: Existing Indian legal framework to address ethical violations in research**

Although the Constitution of India (1950) does not expressly recognize the right to privacy, the Supreme Court has ruled that it is implicit in the Constitution under Article 21 of the Constitution, which states, "No person shall be deprived of his life or personal liberty except according to procedure established by law" (1964). Currently, participants must seek redress for ethical violations in research under a patchwork of acts covering such things as consumer protection, medical malpractice, protections accorded vulnerable groups and acts proscribing penalties for wrongful death.

**Slide Twenty-five through Twenty-seven: Resources**

Case Study: Divide the class up into two groups and have them read and discuss the second case study (20 minutes).
FREQUENTLY ASKED QUESTIONS AND RESPONSES:

1. **What enables achieving adequate privacy during data collection/interviews?**
   - Enabling factors:
     - Well developed rapport with the concerned community, families and other stakeholders.
     - Adequate resources – trained and committed research team, time, finances
     - Good understanding of the community
     - Commitment to ethical conduct of the study at all levels of the institution
     - Opportunities for staff to express concerns and issues with peers and ethics experts when required

2. **Do you think there are any inherent deterrents in achieving privacy?**
   - Cultural constraints pose challenges in India
   - Vulnerable communities need extra protections

3. **What must guide researcher while deciding on continuing research/field work in absence of adequate privacy?**
   - Research participant’s comfort level and consent
   - Assessment of risk to research participants
   - Impact on quality of data

4. **How do researchers deal with ‘privacy’ in situations of focus group discussion or any similar methods of data collection?**
   - Focus group discussion as a research method is primarily used to do exploratory or formative research. The data obtained are used to either design further studies or to design protocols if the topic of enquiry is less researched in the past. This implies that data/information items do not intend to get individual level information. The information collected is of general type – about a phenomenon, about a community, about some practices.
   - The information to be gathered is of a collective ‘perception’ and ‘perspective’ nature.
   - The facilitator does not to divert the discussion to ‘individuals’.
   - Investigators maintain privacy and confidentiality for the entire group during focus groups especially if topics of discussion are of sensitive nature like abortion, women’s health care needs and domestic violence.

5. **From ethics point of view is it mandatory for researcher/research institution to (a) bring the findings of the research in public domain and (b) to prepare material for popular consumption including the participating community in research?**

   It is the ethical responsibility of the investigator to protect the privacy and confidentiality of participants when publishing research findings. Although research ethics are not widely understood in India, national and international research ethics guidelines are explicit about this obligation on part of the researcher/research institute.

   Whether the material must be published for popular consumption depends on the nature of the topic of enquiry and on the commitments researcher have made to the participating community and
individuals. Most applied research in health would ideally, be made public for the greatest social good. If researchers have made commitments in the beginning, it would be ethically binding to fulfill the promises made to the community and/or individual research participants.

6. How does one explain these principles – bringing in the public domain and sharing it with the community - in research ethics? What is the premise?

Two important premises are:
- The resources used for any research activities whether conducted by the public or private sector ultimately are public funds although not always in a literal sense. Therefore, it is incumbent on researchers to provide access to the knowledge. By bringing it in the public domain, investigators also inform peers and help avoid repetition of work and unreasonable depletion of scare resources. ‘Public accountability’ is a key underlying principle that should guide researchers in their decisions about whether to publish.
- In order to be ethical, all research should be of relevance to the society at large. Socially relevant work should feed into activities related to ‘social change’ – advocacy, awareness building etc.
- Resources are limited. It is an ethical responsibility for researchers to use research funds responsibly.

7. Does methodology have any bearing on the extent to which research ethics standards could be upheld?

Research ethics requires that ethical issues are considered from the very beginning of conceptualizing projects and are not simply added on to satisfy research ethics reviews.

8. What are the specific challenges in public health and social science research on HIV/AIDS and in various clinical settings as regards issues like ‘maintaining confidentiality’?
- Accidental knowledge about a participant’s HIV status as the result of routine diagnostics conducted during research activities;
- Obligations regarding partner notification if someone is found to be HIV positive;
- The need to protect the health of HIV positive people may require disclosure of status.

9. Should all applied research have advocacy and action component as part of an ethical responsibility?
- Researchers must ensure that research findings are put to use. They are not required to participate in advocacy.

10. Conflict of principles: which could be the situations wherein the obligation to ‘maintain confidentiality’ conflicts with other research ethics principles? What could be the guiding framework to decide precedence of one over the other, if any?

Examples:
Research participants
- Reporting of life-threatening domestic violence; sexual abuse.
- Revealing information indicating suicidal tendencies.
RECOMMENDED READINGS:

Papers:
Bandewar, S., and M. Sumant (2002). Quality of abortion care: A reality from medical, legal and women’s perspective. This is research report based on our project titled ‘Research and Advocacy Programme for Improving quality of abortion care’. The health care facility based empirical study was conducted in nine tehsils of two districts of Maharashtra.
Ibrahim L. Issues in Medical Ethics
Madhiwalla N. Issues in Medical Ethics

Ethics Guidelines (India): Relevant section from the following guidelines
Module 3 – Privacy and Confidentiality
Case Study 1

Publishing Findings: balancing risks and benefits.

The goal of the research was to improve access to safe abortion care services in a rural area of Karnataka, India. Specific objectives included: (a) understanding the abortion needs of the community; (b) identifying expectations with regard to the quality of abortion care; (c) mapping abortion decision-making processes; (d) assessing the level of knowledge about the Medical Termination of Pregnancy Act (MTP Act) and entitlements to abortion services and; (e) informing advocacy and education programs designed to improve access to safe abortion.

Given the objectives of the research, it was necessary for investigators to publish research findings in both in academic and popular media.

Methodology: The study was designed to ensure that research was culturally sensitive and women-centered. The study area: Data was collected in 6 rural villages where a woman’s organization was actively engaged in gender sensitization development work. The research team: All three investigators were women, of which two were anthropologists by training. Additionally, two women from each of the six villages were hired to facilitate outreach to the communities. Methods of data collection: Investigators utilized three methods for data collection: (a) Focus Group Discussions (FGDs) were used to inform study protocols; (b) screening interviews were conducted to assess awareness and knowledge about the MTP Act and abortion service entitlements; (c) in-depth interviews were conducted with women who had undergone an abortion (12) and; (d) case studies were developed. In-depth interviews were completed over 3-4 sittings of 2-4 hours each. The interviews and period immediately following were recorded. Women were selected for case studies based on their interactions during FGDs and input from women community representatives from each of the six villages. Case studies were completed over 2-4 sittings each lasting for from 2 to 3 hours. No electronic recording methods were used. Field work was completed in one year. Researchers periodically stayed in the communities with families and interacted closely with the community; enhancing the quality of their relationships with participants.

Nature of the data obtained:
- A large amount of information was collected.
- Most data was of a sensitive, intimate, and personal nature.
- Some information revealed many ‘unconventional’ relationships in the community; violence in within families and between spouses; caste dynamics, and sexual politics.
- Women told stories about violence perpetrated by medical practitioners; unethical behavior of doctors and healthcare staff involved with providing abortion services; and illegal abortion practices. Often, identities of individuals involved in these practices were named by community members or research participants, or interviews provided enough detail that individuals could be identified.

Highlights of research findings:
- women had little knowledge about the MTP Act and its entitlements;
- women wanted abortion legislation so that anyone needing services could access them;
- Some participants felt sex-selective abortions should be legal;
- Many women sought abortion care from untrained abortionists and;
- There were many first hand accounts of socially unsanctioned pregnancies where women were willing to trade off their safety to have abortion care.
Module 3 – Privacy and Confidentiality
Case Study 1

Questions:

1. In a study like this, how should researchers ensure privacy and confidentiality during data collection, after data collection, and once the project is completed?

2. What are the ethical challenges in bringing the data and insights gathered from the study into the public domain? Is it ethical for investigators to publish some or all of the material to participating communities in awareness building and advocacy programs?

3. How should researchers deal with information that reveals individual and/or community level crimes and/or illegal practices? (i.e. medical malpractice, local corruption, exploitation of women/or other vulnerable groups by ‘power’ holders?)

4. What are the risks are posed for community members in research, especially data collection processes, as presented in this case study?
Research with Transgenders
Maintaining privacy: Issues and concerns

The study explored biological, psychological and social factors motivating people to join the hijra or transgender community. It also intended to examine the impact of membership in this group, their lifestyle and behavior on their health status and to identify the group’s perceived health needs and health-related help-seeking behavior. Given the paucity of research in this area, the researcher decided to adopt an exploratory qualitative approach to enquire into the subject matter. She took almost six months to establish rapport with the community before starting interviews. In-depth interviews were conducted with 40 transgender individuals using interview guides to allow narratives from research participants. Most of the interviews were held at the residences of participants.

Although researcher expressed the need to have space with individual research participants alone (‘privacy’) during interview, most interviews were conducted in the presence of other members of the household. According to the researcher, both the participant and the other household members preferred to have it that way, although nothing was said explicitly. The researcher went ahead with field work because she decided she could not have control over maintaining privacy and if the participants preferred to have the interviews in the presence of others she could not do anything to prevent that.

Questions:

1. Did researcher do enough to achieve privacy during interviews? Please explain/support your response.

2. If not, what could have been the alternative ways to deal with the situations to ensure ‘privacy’ during interviews?

3. Was it okay for researcher to continue with field work in such a field situation? Please explain/support your response.

4. What could be the implications of not able to maintain ‘privacy’ for the quality of data obtained?

5. What would be the other ‘special groups’ for which parallels can be drawn?

6. What lessons could be learnt from this situation specific?
Case Study: Confidentiality vs. Credibility in Health Services Evaluation

Part I
A study to evaluate the quality of care in one of India’s state Family Welfare programs was undertaken by a group of university-based investigators. Funding for the project was provided by a grant from a European university to the Indian university. As part of the evaluation process, doctors, supervisors, multi-purpose health workers, and family planning clients working in or visiting selected Primary Health Centers (PHCs) in the State were interviewed. The client-provider interactions were also observed for a period of one week. During this period of observation a sterilization camp, which was organized by one of the selected PHCs, was also observed.

An ethical review board consisting of leading researchers in the country was convened to advise the project. The board recommended that all information that could lead to the identification of specific PHCs by those in authority should be specifically avoided. Even mentioning the Taluk (a political division of about 20,000 people) in which the study was undertaken was seen as potentially resulting in repercussions to the PHC or its employees by the National or State government health programs.

The proposal (including a section insuring confidentiality for the PHC and health workers) was then submitted to the Government of India (GOI) Ministry of Health and Family Welfare (MHFW) through the state bureaucracy in order to obtain the permission to undertake the study. The project was approved following review by the National and State governments. Permission from the State government was necessary since the staff at the PHC are technically employees of the State and it is not possible to interview them or obtain any data from the PHCs without the express permission of the State government authorities.

The study began on time and without incident. During the fourth week of the study, a field worker reported the following incident to the principal investigator and asked for some guidance:

“While observing procedures at a local PHC, I noticed that a health worker was reusing one of the syringes. When I told the worker’s supervisor about this practice (I did not identify the worker), I was thanked for my observation and assured that this situation would be rectified. I returned to the clinic one week later to deliver some papers and out of curiosity returned to the outpatient area of the clinic. Once again I observed the practice of reusing syringes. I am unsure how to respond to this situation. The practice may be putting the patients at risk for other diseases but I have guaranteed confidentiality to the clinic and its workers.”

Questions
1. Should the principal investigator undertake any action? If so, what should it be?

2. What advice should the principal investigator give to the field investigator?

Note: Cases are fictional, but based on real events. All individual and organization names have been changed.
Module 3: Privacy and Confidentiality

Case Study 3

Part II
The study was completed on time and the findings revealed that the State’s services with respect to family planning were demand driven and no special efforts had been made to maintain quality. The noticeable absences of national level protocols for service delivery were especially disappointing. Additional problems included the findings that camps for sterilization had been organized with minimal efforts made to accommodate the clients; there were not sufficient water and/or sanitation facilities to meet requirements; and the large number of clients sterilized in a short period of time was in violation of medical protocols. The results also indicated, however, that some PHCs were doing an excellent job and that the quality of services in the PHCs was widely distributed in a bell-shaped curve.

A dissemination workshop was held in the State capital to discuss the findings of the study and was attended by health activists, bureaucrats belonging to the Health Ministry at the National and State level, and medical services personnel. When the findings of the study were reported, the medical services officials and the government representatives requested that the PHCs be identified. They contended that it was possible that the findings of the study were fabricated since it was not possible that such adverse conditions really existed. They suggested that if the names of the PHCs and their staff were identified, the matter could be verified. They also argued that to rectify the situation, if it truly existed, identification was necessary.

Questions

1. Should the names of the PHCs be given to the State (or National) governments and/or the medical services officials?

2. How valid is the argument that if something is to be done, the offending PHCs must be identified?

3. Could the information be given to the interested party without loss of confidentiality?

Case prepared by Mala Ramanathan for: The Program on Ethical Issues in International Health Research, Department of Population and International Health, Harvard School of Public Health
Privacy and Confidentiality

Basic training on Ethical issues in Health Research

Module 3
Privacy and Confidentiality

What is Privacy and Confidentiality?
Module Objectives

By the end of the day the participants should:

1. Be familiar with the concepts of privacy and confidentiality and their application in research ethics
2. Understand ethics guidelines on privacy and confidentiality
3. Appreciate the challenges to privacy and confidentiality
4. Understand legal recourses and protections afforded study participants and the obligations required of researchers
Exercise 1

What do we mean by “privacy”? 
The concept of “privacy”

- Two definitions of “privacy”
- How should a participant’s privacy be protected in a research setting?
- What limits a person’s ability to control access to their private information?
Importance of “privacy”

- Loss of privacy can have important personal and social dimensions
- Protection of privacy enhances research
Context specific challenges to “privacy”

- Restricted space for collection of sensitive information
- Cultural settings that limit individual privacy and autonomy
- Vulnerable groups
- Resource constraints
- Inadequate researcher skills and competencies
Addressing context-specific challenges to “privacy”

Researchers should:

- Understand the community to be studied
- Invest in training and sensitization for staff and community
- Allocate adequate resources
- Seek expert advice
Ensuring Privacy Protections in Research

- Privacy protection should be an integral part of research planning
- Every approach to a client poses a risk for compromising participant privacy
- “Creative” methods to ensure privacy can lead to other ethical problems
Brainstorming

Exercise 2

What do we mean by “confidentiality in the context of research?”
The concept of “confidentiality”

- Two definitions of “confidentiality”
- “Confidentiality” arises from the consent process
- “Confidentiality” is about information and “privacy” is about persons
Importance of ‘confidentiality’

- Protects participants from disclosure of information outside of research context
- Lends credibility to research enterprise
- Allows for research involving sensitive issues
- Builds trust
- Increases candor and validity of responses
Planning for confidentiality

- Investigators should consider confidentiality protection at all phases of research

- Roles, rights and obligations of sponsors, funders and employers with should be clarified in advance
Challenges to maintaining confidentiality

- Overlapping roles in research
- Inadequate training of staff, outreach workers, and volunteers on issues surrounding privacy and confidentiality
- Risk for breach of confidentiality of medical records in some health care settings
Ensuring “confidentiality” in research: recommendations

- Cultivate an atmosphere of respect for the privacy of the people being studied
- Collect identifiable data only if required for scientific reasons
- Ensure that study participants give informed consent
Ensuring “confidentiality” in research: recommendations, cont.

- Safeguard personal identifiers as close to the point of original data collection as possible
- Limit access to personally identifiable data.
- Maintain access ‘audit trails’
- Sensitize, train and certify all personnel who handle personally identifiable data
When are “privacy and confidentiality” NOT required?

- In the public domain:
  - Observation of public behavior
  - Use of public records

- When research participants give informed consent for disclosure of information

- Note: Investigator’s judgment should always apply and research protocols must be approved by the ethics reviewers (IEC) or Institutional Review Board (IRB)
Striking a delicate balance

Obligations and responsibilities of researcher/s & IRBs

- Research participants
- Doctors, community leaders, other individuals with access to information

Researchers & IRBs
Indian Council of Medical Research (ICMR) ethics guidelines

- Features of ICMR guidelines:
  - Inclusion of requirements for “community consent” as well as individual consent
  - Unique standards for disclosure of sensitive information
  - Call for separate consent from participants of researcher publication plans
ICMR ethics guidelines cont.

- Special individual protections in the area of genetic screening

- Anonymous genetic screening is permitted and UNDER CERTAIN CONDITIONS, disclosure to individuals allowed
NCESSRH Guidelines- Social Sciences

- The right whether to remain anonymous or to be identified lies with the participant.

- Participants perspectives on privacy and confidentiality should be given adequate importance.

- Researchers should identify possible breaches of confidentiality and anonymity addressing them prior to research.
Existing Indian legal framework to address ethical violations in research

- Code of Medical Ethics framed under section 33 of the Indian Medical Council Act, 1956
- The Consumer Protection Act, 1986
- The Fatal Accidents Act, 1855
- The Indian Majority Act, 1875
- The Medical Council of India Act, 1956
- The Legal Representative's Suits Act, 1855
- The Medical Termination of Pregnancy Act, 1971
- The Mental Health Act, 1987
- The Pre-natal Diagnostic Techniques Act 1994
Resources

- Cristina Torres: Bioethics and social science research at University of Philippines, Manila, April, 2003
- Mala R: Privacy and confidentiality in health research at the Ethics Training Workshop, AMC, Trivandrum, Keral, Aug, 04
- Ethical Guidelines for Social Science Research in Health, NCESSRH, CEHAT, Mumbai, 2000
- ICMR, Ethical Guidelines for Biomedical Research on Human participants, New Delhi, 2000
Resources, cont.

- Marshall P., Case Western Reserve University, “Public Health Research and Practice in International Settings: Special Ethical Concerns”, 1998


Resources, cont.


- Department of Health and Community Services, Northern Territory Government, Australialia, "Protecting the Privacy of Health Information in the Northern Territory”, 2002

- Program for Appropriate Technology in Health (PATH) and the Global Health Council, “Ensuring Privacy and Confidentiality in Reproductive Health Services”, 2006
SESSION TOPIC 3:
Ethical Issues in HIV/AIDS Research

By the end of the day the participants will be able to do the following:

- Recognize how the context of HIV/AIDS contributes to unique challenges in research ethics.
- Identify the ethical issues involved with HIV/AIDS research.
- Integrate the principals of research ethics into the study of HIV/AIDS.

Preparatory Readings:


Handouts:
- ✓ Case study 1: Privacy and Data
- ✓ Case study 2: Confidentiality

Training Schedule:

Time: 1 hour 30 minutes (45 minutes for case studies and 45 minutes for presentation and discussion)

Facilitator Notes:

Case Study: Divide the class up into two groups and have them read and discuss the first case study (20 minutes).

Presentation (45 minutes): The session is divided into two components. The first component describes the ethical challenges in HIV/AIDS research and the second part on addressing those challenges.

Slide One: Module Title
Slide Two: Module Objectives
Slide Three: Why are there unique ethical challenges in HIV/AIDS research?

The ethical challenges in HIV/AIDS research arise out of the:

- Historical context of the disease;
- Implications stigma for research participants;
- Epidemiology of HIV/AIDS; and
- Global inequities.

Each of these is discussed separately in the next slides.

Slide Four: Historical Context
Early timeline that associated HIV/AIDS with gay men, foreign locations and high risk groups:

- 1978 – 1982: What would later be called AIDS is first detected as rare forms of pneumonia (Pneumocystis carinii) and cancer (Kaposi Sarcoma) in gay men in California.
- 1978: The first cases of AIDS were detected in Haiti.
- 1986: Injection drug use is identified as a significant risk factor for HIV in studies of drug users in New York.

Slide Five: Stigma

HIV is stigmatized because:

*HIV infection is associated with socially unacceptable risk behaviors and conditions*

These include:

- Men having sex with other men.
- Sex with multiple partners.
- Injection drug use where a person shares needles, syringes, cookers, or other equipment.
- Infection with sexually transmitted diseases such as syphilis or genital herpes.

*Marginalized vulnerable groups are linked with the disease.*

“HIV/AIDS is associated with marginalized behaviors and groups. In many settings, men may fear revealing their HIV status because it will be assumed that they are homosexual. Similarly, women may fear revealing their serostatus because they may be labeled as “promiscuous” or sex workers.”

*Taken from: “HIV/AIDS-related Stigma and Discrimination: A Conceptual Framework and an Agenda for Action”, Horizons Program, 2002*

*HIV is associated with immorality, crime and death.*

According to research by Gilmore and Sommerville, many language metaphors used to refer to HIV/AIDS give clear indications of the stigma associated with it:

- AIDS is death (both biological and social)
- AIDS is punishment (for immoral and sinful behavior like homosexuality, promiscuity, injecting drug use and commercial sex)
- AIDS is a crime (HIV infected people are “criminals”, guilty of harming or threatening the health and welfare of their “innocent” victims)
- AIDS happens only to others (“them”), not to me/us (“us”): the world is dichotomized into the “infected” and the “not infected” (the “dying” and “the living”)
- AIDS is a horror; the infection is seen as an abject, terrorizing invader or demon.

*Taken from: Understanding HIV-Related Stigma By Salvator Niyonzima, UNAIDS Advisor for the Greater Involvement of People Living with or affected by HIV and AIDS (GIPA)*

Ver may07
There is a lack of knowledge and awareness about the condition.

“Among the public at large, there is still a profound lack of knowledge and awareness about HIV/AIDS -- especially among young people. Recent surveys from more than 40 countries show that more than half of all adolescents and young adults have serious misconceptions about HIV/AIDS, and about how the virus is transmitted.”

Taken from: Secretary-General Kofi Annan’s remarks for the launch of the United Nations Global Media Initiative on HIV/AIDS in New York, January 15, 2004:

HIV treatment is available only to a privileged few.

According to UNAIDS, although more people than ever before received antiretroviral treatment in 2005, only a fraction of people who needed treated were receiving it. In southern Africa, only 10% of HIV-positive individuals were treated with anti-HIV drugs this year, and only marginally more – one in seven – received antiretroviral therapy in Asia. Most of the 3 million HIV-related deaths which occurred in 2005 could have been prevented with appropriate HIV treatment.

Slide Six: The Epidemiology of HIV/AIDS

As of December 2005, between 36 million and 45 million people was living with HIV.

At present rates total global infections will reach 81.7 million by 2010. (WHO-UNAIDS 2002)

Approximately 90% of all infections occur in the developing world.

In spite of this:

- Only one in seven Asians who need ART was receiving it at the end of 2005.
- Only 50,000 people in sub-Saharan Africa, where an estimated 4.1 million people are infected with HIV, currently have access to treatment (Attawall and Mundy 2003).
- Only 5% of mothers in the 30 African countries with the highest HIV prevalence have access to programs preventing mother to child transmission of HIV (MTCT)

Nearly half of the infected population ranges in age from 15 to 24 years.

There are 10 million youth currently living with HIV/AIDS, of which 6.2 million live in sub-Saharan Africa and 2.2 million in Asia. In the Caribbean and sub-Saharan Africa, young women are two to three times more likely than men to be HIV-positive.

The number of women living with HIV is roughly equal to the number of men who are HIV infected.

By the end of 2005, women accounted for nearly half of all people living with AIDS worldwide, and represent almost 60% of infections in sub-Saharan Africa. The impact of HIV on women is also growing in Eastern Europe, Central Asia and South and South-East Asia. Moreover, young women are several times more likely than young men to contract the disease through heterosexual contact. Worldwide, 62% of infected young people are girls, and that number soars to 77% in sub-Saharan
Africa. A woman's vulnerability to the virus is attributable not only to biological differences, but also to deeply entrenched socio-economic inequalities that further compound her risk.

Data taken from:


Slide 7: Global Inequities

The income gap between the richest billion and poorest billion people on the planet is 80-fold and the difference in life expectancy is 27 years.

To illustrate the difference between the richest and the poorest countries in the world:

- Three billion people live on less than one dollar a day; 3 billion live on under two dollars a day; 1.3 billion have no access to clean water; 3 billion have no access to sanitation; 2 billion have no access to electricity.

- The GDP (Gross Domestic Product) of the poorest 48 nations (i.e. a quarter of the world’s countries) is less than the wealth of the world’s three richest people combined.

- 20% of the population in the developed nations consumes 86% of the world’s goods.

- Approximately 790 million people in the developing world are still chronically undernourished, almost two-thirds of whom reside in Asia and the Pacific.

- Most of the world's shortest life expectancies occurs in Africa where the AIDS epidemic, malnutrition, curable diseases, and civil strife have taken a tremendous toll on human life. In all, of the 29 countries where life expectancy at birth is 50 years or less, 28 are in Africa.

Sources:

5. World Resources Institute Pilot Analysis of Global Ecosystems, February 2001

Of the $80 billion spent annually on health research, less than 10 per cent is devoted to health problems in the developing world.
The World Health Organization’s Commission in Macroeconomics and Health first noted what is termed the “90/10” gap. Of the vast US $80 billion spent annually on health research, including both public and private sectors, less than 10 per cent is devoted to health problems in the developing countries where 90 per cent of the world health problems reside.

*Between 1995 and 1999, the proportion of new drugs approved for use in the United States on the basis of trials carried out in foreign countries tripled, from 9 to 27 per cent.*

“Between 1995 and 1999, the proportion of new drugs approved for use in the United States on the basis of trials carried out in foreign countries tripled, from 9 to 27 per cent. There are three reasons why this trend will continue under increasing pressure for more clinical research in developing countries.

First, there will be a growing need to test new preventive vaccines and drugs for diseases such as HIV, malaria, tuberculosis and dengue fever. Since the majority of people exposed to, or suffering from, these diseases live in developing countries where many of the trials will need to take place.

Second, the revolution in genomics and its downstream technologies means that the number of potential new drugs that need testing is set to escalate rapidly. Already in the United States, millions of individuals participate in about 70,000 clinical trials each year. The need for even more research will add to the pressure to do research in developing countries, where in many instances the research may additionally be carried out at lower cost.

Third, there will be ongoing, appropriate pressure to correct the 10/90 gap — the fact that of the US$70 billion spent on health research annually, only 10 per cent is used for research into 90 per cent of the world’s health problems — by focusing research on diseases representing the heaviest burden.”

*Abdallah S Daar and Peter A Singer, Human capital is key to research ethics, 25 April 2002, SciDev.Net*

**Slide 8:** Ethical challenges arising from the context of HIV/AIDS

“As the HIV epidemic continues to spread, clinical and prevention trials are needed in developing nations to learn how best to alleviate suffering. Such international trials, however, raise ethical concerns because of great disparities in wealth, power, medical infrastructure, and a history of exploitation.”

*Bernard Lo, Ronald Bayer, Establishing ethical trials for treatment and prevention of AIDS in developing countries, BMJ 2003;327:337-339 (9 August), doi:10.1136/bmj.327.7410.337*

**Slide 9:** The Challenges must be considered in the context of ethical concerns

These concerns are embodied in various widely accepted ethical guidelines:

**Informed Consent:**

“In any research on human beings, each potential participant must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study, and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study, and that he or she is free to withdraw his or her consent to participation at any time.”
The Declaration of Helsinki (1964)

Privacy and Confidentiality

“Every precaution should be taken to respect the privacy of the participant, and to minimize the impact of the study on the participant's physical and mental integrity, and on the personality of the participant.”

The Declaration of Helsinki (1964)

Concerns about Special Groups

“Individual justice in the selection of participants would require that researchers exhibit fairness: thus, they should not offer potentially beneficial research only to some patients, who are in their favor, or select only "undesirable" persons for risky research. Social justice requires that distinction be drawn between classes of participants that ought, and ought not, to participate in any particular kind of research, based on the ability of members of that class to bear burdens, and on the appropriateness of placing further burdens on already burdened persons.”

The Belmont Report (1979)

Risks and Benefits

“Every biomedical research project involving human participants should be preceded by careful assessment of predictable risks, in comparison with foreseeable benefits to the participant or to others. Concern for the interests of the participant must always prevail over the interests of science and society.”

Declaration of Helsinki (1964)

Standards of Care

"The benefits, risks, burdens and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods."

Declaration of Helsinki (1996)

Integrity & Conflict of Interest

“Researchers should have no undisclosed conflict of interest with their collaborators, sponsors or participants. Thus, researchers must disclose actual, apparent or potential conflicts of interest to the Ethical Review Committee. All sponsorship of research should be publicly acknowledged. There is no justification for secrecy. All results of a study, whether government or industry-sponsored, are the intellectual property of the investigators, not the sponsor, and results should always be published if they have scientific merit. Requests to withhold findings, to change or tone down the content of a report or to delay publication of results should be categorically refused.”


Social Justice

Ver may07
“Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most.”


**Slide 10: Informed consent and research on HIV/AIDS**

Obtaining truly informed consent can be challenging in HIV/AIDS research because of:

*The complexity of research designs.*

“Participants in an HIV vaccine trial should understand at least the following: the rationale for the study (such as the reason for developing a local HIV vaccine); technical issues (of the nature of the products); technical consequences (possible side effects); unknown outcomes (that there is no guarantee that HIV vaccines will offer any protection against HIV infection); methodological issues (placebo or randomization); practical aspects involved in personal participation (e.g., the kinds of procedures and tests that participants will undergo); the costs and benefits of participation in the study (e.g., reduced benefits from future vaccines or access to treatment); and the personal implications of participation in the study (e.g., discovery of one’s HIV status and the psychosocial effect of this knowledge).”

*HIV vaccine trials: critical issues in informed consent. G. Lindegger* and *L.M. Richter*  
*South African Journal of Science 96, June 2000 313*

*Diminished autonomy of potential participants.*

Informed consent is premised on the notion that individuals have the right and the ability to make decisions and act upon them. In many settings, this ability is often constrained by a range of factors. In many settings, important decisions are not made by individuals but are the result of consultation with family members, employers, or the community. This is particularly true for many women in settings where decisions are traditionally made by men. Women may not have the autonomy or the legal right to make the kinds of decisions encompassed by informed consent. Issues of autonomy and decision making are especially complex for HIV prevention trials since they involve highly charged issues concerning sex, trust, gender and power. In addition, many groups at high risk for HIV such as sex workers, men who have sex with men (MSM), and injection drug users engage in socially unacceptable and even illegal activities that place them at special risk for coercion.

*Problems with voluntariness and possibilities for coercion in developing country settings.*

The CIOMS Guidelines define informed consent, as a decision to participate in research made by a competent individual who has received the necessary information; has adequately understood the information; and after considering the information, has arrived at a decision without having been participantd to coercion, undue influence, inducement, or intimidation.

Relatively small compensation my impair voluntariness in settings with high levels of poverty. Intimidation and undue influence are also concerns if prospective participants receive therapeutic attention from the recruiting physicians unrelated to the study and if potential participants fear that nonparticipation in the research will prejudice the therapeutic relationship. Investigators must also be careful that potential participants will not suffer from “therapeutic misconception”: a mistaken belief that participation in research would not be recommended if the doctor did not think it would
directly benefit the individual. In addition, in some settings, potential participants are susceptible to coercion by close relatives, employers, and community leaders that may have an undo influence on a participant’s decision.

**Slide 11: Privacy and Confidentiality**

*Non-consensual disclosure of a participant’s HIV positive status can result in social stigmatization, denial of work, and loss of access to medical services.*

HIV-related stigma is linked to preexisting notions about the association of HIV infection with behavior such as injected drug use, men having sex with men or commercial sex work. This stigma often translates into discrimination against HIV positive people. In many developing countries, stigmatized individuals may be barred from entry to educational institutions, terminated from employment, and denied healthcare. In addition, women may also be participated to violence or abandonment by their male partners if they are found to be HIV positive.

*It may be impossible in some clinical settings to ensure confidentiality*

Ensuring confidentiality is a challenge in many developing world clinical settings. Often, testing and trial centers are in public view. Lack of adequate space in healthcare facilities makes provision of privacy difficult, and staff and clinicians have a notion of “shared confidentiality” in HIV testing.

*In some developing countries like India, certain groups are not guaranteed confidentiality under the law.*

Certain groups in developing countries, most notably adolescents at high risk for HIV infection, have no guarantee of privacy or confidentiality under the law. Existing legislation is paternalistic, based on the view that persons below a certain age do not possess the ability to make certain decisions. This view is reinforced by providing an age bar for marriage, contracts etc. In most Indian laws persons below the age of 18 are referred to as minors.

Issues of primary concern for children affected by HIV/AIDS relate to mandatory testing policies and the preservation of confidentiality. For children and adolescents, this is problematic as they are not recognized as persons who can or should have access to sexual or general health services without a guardian. Not only does this restrict the rights of children in general, the system also does not account for a large percentage of children who live and work outside family structures. Legal strategies in other countries have been reformed accordingly to empower children (by specifying requirements in terms of age and the ability of the child to understand the nature of the diagnosis or treatment) to consent to testing and provide them the same rights as adults vis-à-vis confidentiality.

The issue of confidentiality for minors also arises in educational/institutional settings. Generally, information regarding the HIV status of a minor or her/his parents cannot be shared and should be disclosed based only on pre-determined protocols. Children in institutional care are frequently participated to mandatory testing, breach of their HIV status and discrimination. Legislation should outline the circumstances in which minors in institutional care who are incapable of understanding the nature of the diagnosis or treatment can be tested and also protect their right to confidentiality.

*Taken from: Lawyers Collective, HIV/AIDS, Children, found at: http://www.lawyerscollective.org/lc_hivaids/draftlegislation/Abstracts/Children.htm?Menu=1*
**Slide 12: “Vulnerable Groups”**

“Vulnerable Groups” in the context of HIV/AIDS research, have two characteristics: They are subpopulations that are known from biological testing to have high levels of HIV including commercial sex workers, Men who have Sex with Men, injection drug users, and migrant and mobile populations and; groups that have heightened vulnerability due to reduced autonomy or biological and psychological characteristics (children, the mentally disabled, those suffering mental illness), structural causes (the poor or "economically disadvantaged"), and situational sources (women, prisoners, students, members of the armed forces).

**Slide 13: Vulnerability – An Example**

Under section 377 of the Indian Penal Code, homosexual acts are a punishable offence: “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with 152 [imprisonment for life], or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.” IPC

**Slide 14: Risks associated with HIV/AIDS research in “Special Groups”**

Investigators utilizing “Special Groups” in HIV/AIDS should recognize the potential for:

- Promoting a narrow HIV prevention and treatment focus
- Reinforcing existing stereotypes and stigma regarding vulnerable populations
- Mischaracterizing a dynamic epidemic where affected groups change over time.
- Disseminating information in a way that increases risks for vulnerable groups.

**Slide 15: Risks and Benefits**

Making the decision to participate in an HIV/AIDS study or clinical trial is a complex and personal process and it is important that all potential volunteers fully understand the risks and benefits when making this choice.

**Slide 16: Risks of participation in HIV research or clinical trials**

The potential risks of participating in HIV/AIDS research and clinical trials can include a variety of risks including adverse reactions caused by a drug or vaccine under study, psychological stress, loss of privacy and confidentiality, stigma, and possibility of discrimination.

Potential participants must also be told that a drug or vaccine candidate may not be effective, or that they can be randomly selected at the start of the trial to receive a placebo. Either way, the volunteers may not have protection against HIV infection during trial participation, and must practice risk-reduction behaviors.

Other potential risks include the possibility of receiving a false-positive HIV test result in the future, being unable to donate blood after participation in the trial, and social stigma and possible discrimination.

**Slide 17: Benefits of participation in HIV research or clinical trials**

HIV/AIDS research can have positive benefits for both individuals and the communities where the study takes place. Related educational campaigns raise awareness about HIV transmission and prevention that benefit all community members and outreach programs promote voluntary counseling and testing (VCT) programs and reduce stigma.
There are also benefits for individuals including availability of VCT services and risk-reduction counseling, access to prevention methods including male and female condoms, and the psychological reward of being involved in medical research that may benefit others. Other possible benefits include the basic medical care that volunteers receive during the trial, and referrals to treatment programs and support groups.

Volunteers in AIDS vaccine trials may receive reimbursement for transportation and for food if they are expected to be at the site during a mealtime. Researchers and the ethics committees take these considerations seriously because they don't want the compensation or the health care provided at the trial sites to be the reason that people join a study. All trial organizers and approval bodies work carefully to avoid undue inducement. Study sides may strive to provide a level of care that is consistent with what is available in the broader community or extend some basic healthcare services to the wider community.

**Slide 18: Standard of Care**

“The interpretation of "standard of care" in research has generated a lot of controversy among researchers. It has underpinned much of the debate on the use of placebos in randomized controlled trials such as the one around the zidovudine trials, which were proposed to prevent mother to child transmission of HIV infection in Africa. These trials entailed an evaluation of a short course treatment regimen in comparison with a control population receiving nothing. A high profile debate ensued that led to a reconsideration of guidelines on international research as well and spurred initiatives to make low cost antiretroviral treatment available in developing countries.

In October 2000, the World Medical Association modified the Helsinki declaration to state that "the benefits, risks, burdens and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods." The Council for International Organizations of Medical Sciences guidelines took the debate a stage further by using the term "established effective therapy" to indicate a degree of consensus and acceptability among health professionals about the nature of treatment 7 But crucially, these guidelines did not specify if established effective therapy applies to a local or global context. Given the paucity of relevant health research in developing countries, aspiring for best standards of care may make research in these countries irrelevant and unsustainable.

Total absence of care or health services cannot be considered a suitable control standard. Nor can harmful practices in a dysfunctional system, such as unsafe injections or female circumcision. Whether best standards of care should reflect the best available western care or an international standard of care is undecided. Recommendations and management protocols from the World Health Organization, the closest we have to international standards, do not cover all disorders and circumstances and assume a certain level of performance of health system.”


**Slide 19: Conflict of Interest & Integrity**

“Academic institutions are privileged to serve as a public trust for the advancement, preservation, and dissemination of knowledge. These institutions have diverse obligations: to students, faculty, and staff; to legislators and regulators; to donors and benefactors; and to society at large. When meeting these obligations in the ordinary course of business, institutions must and do
reconcile competing interests. In so doing, institutions recognize widely that policies must be made and decisions taken in a manner that is free of the taint of improper bias or conflict of interest.

Increasingly, academic institutions that conduct research also invest in -- and accept the philanthropy of -- commercial research sponsors. Regulators, legislators, journalists, and patient advocates have now begun to question whether such financial relationships may give rise to "institutional" conflicts of interest that could threaten research integrity and, especially troubling, potentially pose risks to human research participants. Concern has arisen that existing institutional processes for resolving competing interests may be insufficient when the institution has a financial interest in the outcome of research and the safety and welfare of human participants are at stake.

Although perceived risks to human participants have received the greatest attention thus far, the growing perception that research institutions may have financial conflicts of interest also threatens to weaken public support for research. In an era of tremendous public investment in academic research, legislators and policymakers and others justifiably expect heightened public accountability from research institutions.”

Taken from: Protecting Participants, Preserving Trust, Promoting Progress II: Principles and Recommendations for Oversight of an Institution's Financial Interests in Human Participants Research, Task Force on Financial Conflicts of Interest in Clinical Research, American Association of Medical Colleges.

**Slide 20: Social Justice**

Researchers must:

- Ensure the local relevance of research in the context of shifting priorities in international funding and collaborations.
- Facilitate universal access to the products of research.

Case Study: Divide the class up into two groups and have them read and discuss the second case study (20 minutes).
Estimation of HIV Incidence Using Laboratory Records

Safety of blood supply is a major public health concern especially during the HIV epidemics. In countries where HIV transmission is high, an increased risk of HIV infection can be from blood donations made during the so-called ‘window-period’-the time between the onset of infection and the development of detectable antibodies in a person recently infected with HIV. Blood banks would try to estimate how likely this ‘window-period’ can happen and try to find means to defer these donors. To estimate the probability that one can get HIV infection during this ‘window-period’, one needs to determine rates of new infection (incidence), then such probability can be estimated. Blood banks usually have good sources of donor records and would provide opportunity for the estimation. A group of researchers tries to study this issue using computerized donor records from a university blood bank.

Donor records are usually entered into computer files, each record generally includes patient’s full name, age, birth dates, sex, a unique donor number (similar to hospital or clinic number), addresses, date of donation, blood group and results of serologic tests (HIV, HBsAg, and VDRL). Names, surnames, and unique donor numbers are used for blood bank identification purpose and are treated as confidential by blood banks. Researchers, however, need to obtain these data to cross check for their validity.

Questions:

1. Is it ethically acceptable to carry out a study of this type?

2. If it is, do researchers need informed consent from these donors?

3. Is it ethically acceptable for blood banks to release these data to researchers? If it is, how and to what extent can one maintain confidentiality of their donors? How can confidentiality best be protected in data management, analysis, and reporting?

4. Should potential donors be told that their records might be used for epidemiologic investigations other than for blood donation purpose?
Module 3: Ethical Issues in HIV/AIDS Research
Case Study 2

Assessing Impact of a PPTCT Programme

National AIDS Control Organisation (NACO) has initiated special programmes in high HIV prevalence (more than 1% in general population, as estimated by sentinel surveillance rates among women attending selected antenatal clinics) states to prevent parent to child transmission (PPTCT) of HIV. After obtaining encouraging results from pilot programmes in 11 sites, this intervention was scaled up to include all high prevalence states. The aim of the programme is to reduce the rate of transmission from mother to children. The impact of this intervention can be measured only 18 -24 months subsequent to the initiation of the programme, as only after 18 months would the mothers' HIV antibodies clear from the babies' blood. It would then be possible to determine the HIV antibody status of the babies. Before this time, babies' status may be ascertained by PCR but this is too expensive to form part of a national programme.

A high prevalence state in Southern India initiated the Prevention of Parent to Child Transmission (PPTCT) program in all district hospitals in January 2003. The programme involved screening consenting pregnant women for HIV. If tested positive, the women were provided psychosocial support, urged to reveal their status to their partner and bring them in for couple counselling and testing. The women were encouraged to return to the same institution for delivery. At the time of delivery, positive women were administered a single dose of Nevarapine at the onset of labour and the baby was also given Nevarapine syrup within 72 hours of birth.

A considerable proportion of women do not return to the diagnosing institution for delivery, for various reasons including discrimination and additional expense of universal precautions that are adopted by the health personnel. When a woman indicates her inability to return for delivery she may be given Nevarapine tablets with instructions on when to take it. This home administration, however, is not possible for infants as the dosage is dependent on the weight of the new born.

One of the key indicators of programme effectiveness is the number of children in whom HIV was prevented. Therefore the program required women to return at 6 months, 12 months and 18 months after delivery for testing the children for HIV. When asked to return for follow-up, many women said that they couldn’t afford it because the distance was too much and they would have to lose their day’s wage. Some said that their experience in the hospital had been so bad, that they would not want to come. Also there were others who said they did not want to know the child’s status because they would gain nothing from knowing it and it would only cause them more pain.

During a review meeting, team leaders were brainstorming about how to increase Nevarapine coverage and follow-up after delivery. One of the suggestions was to involve the ANM in follow-up for women who deliver at home, and administer Nevarapine to the baby with the stipulated time. Then the ANM could be involved in providing continued support to the positive mother with regard to following exclusive breast feeding or exclusive replacement feeding, early session of breast milk and, other needs of the mother and child. ANMs in the state have undergone training and have been oriented to the issues, and should be able to maintain confidentiality. However, many team leaders felt that ANMs who were essentially part of the community would not be able to maintain confidentiality, and informing ANMs would be a breach of confidentiality and violation of informed consent. If an ANM makes an unusually large number of visits to one mother than family and community members will begin to suspect that there is something wrong, and confidentiality may be inadvertently broken.

Another suggestion was to provide compensation to the woman for returning for follow-up. Some suggested Rs.500. But others felt it was far too much and felt that Rs.100 would be sufficient and would cover the travel cost of not just the woman but also two others who invariably accompany a woman. The other suggestion was to conduct sensitisation for hospital
staff so that they do not discriminate positive persons. But most team leaders were very skeptical because they felt it was a recalcitrant issue and dealing with stigma and discrimination was a long-term process, which was beyond the scope of the present programme.

Questions:

1. Should the informed consent procedure be changed to include revelation of HIV status to health personnel including ANMs?
2. Whose interests are paramount? The mother's, the baby's, that of the family?
3. How does the concept of ‘shared’ confidentiality work in the context of health services, particularly in small/closed communities?
4. Can this problem be addressed without addressing issues related to stigma and discrimination in the community?
5. From whose point of view are the various strategies being discussed?
6. Whose need is it to test a child?
7. Can a researcher test a child if the mother gives consent but says she does not want to be told?
8. If so, how will this conflict with the researcher’s responsibilities towards the child?
9. What is appropriate compensation in this situation?
Ethical Issues in HIV/AIDS Research in India

Basic Training on Ethical Issues in Health Research

Module 4
Module Objectives

By the end of the module participants should be able to:

- Recognize how the context of HIV/AIDS contributes to unique ethical challenges in research.
- Identify the ethical issues involved with HIV/AIDS research.
- Apply research ethics guidelines to the study of HIV/AIDS.
Why are there unique ethical challenges in HIV/AIDS research?

- Historical context
- Stigma
- Epidemiology of HIV/AIDS
- Global inequities
**Historical Context**

- HIV/AIDS inextricably linked the disease in the public imagination with gay men, foreign settings, and high risk groups.

- This leads to:
  - A focus on individual behaviors and risks
  - A lack of perceived risk among the general population
  - Neglect of groups at seeming “low risk” such as women and heterosexuals
  - A focus on epicenters / “hot spots” instead of the general public
  - A lack of appreciation of the larger cultural, political and socio-economic processes contributing to HIV/AIDS
HIV/AIDS is stigmatized because:

- HIV infection is associated with socially unacceptable risk practices and conditions.
- Marginalized vulnerable groups are linked with the disease.
- HIV is associated with immorality, crime and death.
- There is a lack of knowledge and awareness about the condition.
- HIV treatment is available only to a privileged few.
As of December 2005, between 36 million and 45 million people were living with HIV.

Approximately 96% of all infections occur in the developing world (Global Health Council 2005).

Nearly half of the infected population ranges in age from 15 to 24 years.

The number of women living with HIV is roughly equal to the number of HIV infected men.
Global Inequities

- The income gap between the richest billion and poorest billion people on the planet is 80-fold and the difference in life expectancy is 27 years.

- Of the $80 billion spent annually on health research, less than 10 per cent is devoted to health problems in the developing world [90/10 gap].

- Between 1995 and 1999, the proportion of new drugs approved for use in the United States on the basis of trials carried out in foreign countries tripled, from 9 to 27 per cent.
Ethical Challenges Arising from the Context of HIV/AIDS

Some ethical challenges in HIV research include:

- Gaining access to and working with communities
- Minimizing risks associated with particular study designs and data collection methods
- Developing appropriate standards of care
- Managing threats to integrity and handling conflicts of interest
- Addressing issues of exploitation and justice
Considering Challenges in Context of Ethical Guidelines

- Informed Consent
- Privacy and Confidentiality
- Vulnerable Groups
- Risks and Benefits
- Standards of Care
- Integrity & Conflict of Interest
- Ensuring justice
Obtaining truly informed consent can be challenging in HIV/AIDS research because of:

- The complexity of research designs.
- Diminished autonomy of potential participants.
- Problems with voluntariness and possibilities for coercion in developing country settings.
Privacy and Confidentiality

HIV/AIDS research presents special challenges for researchers

- Non-consensual disclosure of a participant’s HIV positive status can result in social stigmatization, denial of work, and loss of access to medical services.

- It may be impossible in some clinical settings to ensure confidentiality.

- In some developing countries like India, certain groups are not guaranteed confidentiality under the law.
“Vulnerable Groups”

Much of HIV/AIDS research focuses on groups that have diminished autonomy and heightened vulnerability including:

- Women
- Sex workers
- Men who have sex with men
- Children and adolescents
- Injection drug users/ alcohol users
- Migrants and mobile populations
- Prisoners
Vulnerability – An Example

- Under section 377 of the Indian Penal Code, homosexual acts are a punishable offence:
  
  o “Whoever voluntarily has carnal intercourse against the order of nature with any man, woman or animal, shall be punished with 152 [imprisonment for life], or with imprisonment of either description for a term which may extend to ten years, and shall also be liable to fine.”

IPC
Researchers involving vulnerable groups must recognize the potential for:

- Heightening risk of incarceration or violence
- Promoting a narrow HIV prevention and treatment focus
- Reinforcing existing stereotypes and stigma regarding vulnerable populations
- Mischaracterizing a dynamic epidemic where affected groups change over time.
- Disseminating information in a way that increases risks for vulnerable groups.
Risks and Benefits

- Making the decision to participate in an HIV/AIDS study or clinical trial is a complex and personal process and it is important that all potential volunteers fully understand the *risks* and *benefits* when making this choice.
Risks of Participation in HIV Treatment and Vaccine Trials

Risks include:

- Side effects or adverse reactions;
- A possibility that the intervention or drug under study will not be effective or that they will be selected to receive a placebo and won't be protected against HIV infection;
- The possibility of receiving a false-positive HIV test result in the future and being unable to donate blood after participation; and
- Social risks such as facing possible stigma or discrimination.
Benefits of Participation in HIV Research

There are also several possible benefits for those who decide to participate in HIV/AIDS research:

- Access to VCT services and risk-reduction counseling
- Continuous access to the best available prevention measures in their community
- Medical care and referrals to treatment and support programs
- Appropriate reimbursement for transportation or food.
Standard of Care

The Standard of Care debate over a “universal standard” vs. “established effective therapy” raises important questions for HIV/AIDS researchers:

- When should ARVs be part of the ‘standard of care’?
- Increasingly, HIV prevention trials regardless of where they are being conducted are committed to providing ARVs – question is how should access be ensured?
- Should benefits accrue only to the individual or should it extend to the family?
- How can sustainability and long term care be addressed?
Conflict of Interest & Integrity

Challenges:

- Preserving the continued trust of research participants and the public.
- Acknowledging potential conflicts of interest.
- Publishing all scientifically relevant findings both negative and positive.
- Giving proper academic credit and acknowledgement.
Social Justice

- Ensuring local relevance of research in the context of shifting priorities in international funding and collaborations.
- Facilitating universal access to the products of research.
Session Topic 5:
‘Standard of Care’ in Health Research

By the end of the day the participants should be able to:

- Understand the different approaches used to evaluate ‘standard of care’ (SOC) in health research.
- Understand the advantages and disadvantages of each approach to SOC in health research.
- Identify the main sources of national and international guidance.
- Understand the issues and debates surrounding ‘standard of care’ in health research in India.

Preparatory Readings:

A New Look at International Research Ethics - Education and Debate
British Medical Journal, Sept 30, 2000 by Solomon R Benatar and Peter A Singer found at:
http://www.findarticles.com/p/articles/mi_m0999/is_7264_321/ai_66449665

THE STANDARD OF CARE DEBATE: CONCEPTUAL CLARIFICATIONS, Adnan A. Hyder,
American Journal of Public Health, December 2004, Vol 94, No. 12 found at:
http://www.ajph.org/cgi/content/full/94/12/2048

Handouts:

✓ Case study 1
✓ Case study 2

Training Schedule:

Time: 1 hour 30 minutes (45 minutes for case studies and 45 minutes for presentation and discussion)

Facilitator Notes:

Case Study: Divide the class up into two groups and have them read and discuss the first case study
(20 minutes).

Presentation (45 minutes):

Slide 1: Title Slide

Slide 2: Module objectives

By the end of the session participants should be able to:

- Understand the different approaches for evaluating standard of care (SOC) in health research and discuss the advantages and disadvantages of each.
- Recognize the special ethical dilemmas involving use of placebos in clinical trials.
- Identify sources for national and international guidance on SOC.
- Understand some of the controversies surrounding SOC in India.
Slide 3: Standard of Care (SOC) - Definitions

The following definitions on SOC are provided by the Nuffield Council on Bioethics:

- **Standard of Care**: The nature of the care and treatment that will be provided to participants in research.

- **Universal Standard of Care**: The best treatment available everywhere in the world.

- **Non-universal Standard of Care**: The treatment available in a certain region as part of the public health system.


Slide 4: International guidance for ‘standard of care’

Some experts have argued that no patient participating in a clinical trials should be denied the 'standard of care' available in developed countries like the US. They cited Principle II-3 of the Declaration of Helsinki which states trial participants 'should be assured of the best proven and diagnostic method'.

Slide 5: Challenges of applying principle II-3 of the Declaration of Helsinki

A strict interpretation of II-3 would exclude almost all controlled trials whether the control group received no treatment (with or without a placebo) or a comparison treatment which was less than the optimal treatment available in a developed country.

Slide 6: Clarifying the meaning of II-3

The Council for International Organizations of Medical Sciences (CIOMS), World Health Organization, Geneva, Switzerland, has clarified the controversy with guidelines stating that the ethical principals in the Declaration of Helsinki “could be effectively applied, particularly in developing countries given their socio-economic circumstances, laws, regulations and executive and administrative arrangements'. Furthermore, the Guidelines state that research in developing countries needs to be 'responsive to the health needs and the priorities of the community in which it is to be carried out'.

Slide 7: Approaches to evaluating ‘standard of care’

Research can be evaluated against a:

- ‘Universal standard of care’ equivalent to the best current method of treatment available anywhere in the world for a particular disease or condition.

“Those who favor providing the best-known intervention as the ethical standard argue that to do otherwise constitutes a fundamentally unjust double-standard and that participants not receiving the best known interventions could suffer from preventable harm. Also, it can be argued that international research initiatives are legitimate vehicles through which global inequalities in access to health care can be reduced. Conforming to a universal standard also avoids inconsistencies in the care provided among different sites in a multi-country study. To achieve
the necessary numbers, trials frequently enroll participants in many countries and sites and then pool the data for analysis. If all decisions are negotiated locally based on local realities, different people in the same trial could receive different levels of care.”

Taken from: Global Campaign for Microbicides, Defining “Benefits” and “Standard of Care”. Found at: http://www.global-campaign.org/clientfiles/chapter7.pdf

- ‘Non-universal standard of care’ equivalent to the best proven diagnostic and therapeutic method available in the country where the research is being conducted.

Opponents to a “universal standard” argue that it is simply not realistic to apply a one-size-fits-all intervention to locations where the existing infrastructures for health care delivery cannot support the “best proven therapy” for the local population. In the AZT study to prevent maternal-fetal transmission of HIV, for example, opponents of the ‘universal standard of care’ point out that providing control groups with the placebo was, in fact, providing them with the locally available ‘standard of care’. Moreover, opponents of a universal approach call attention to the fact that local governments and health professionals were actively involved in reviewing and approving the study design. There was, in fact, broad approval for the study by the World Health Organization; a panel convened by WHO recommended that there was an urgent need to find less costly drug regimens for preventing HIV maternal-fetal transmission, noting that randomized controlled trials would be the most effective way to quickly produce scientifically valid results.

Taken from: Public Health Research and Practice in International Settings: Special Ethical Concerns. Patricia A. Marshall, Case Western Reserve University. Found at: http://www.asph.org/UserFiles/Module3.pdf

Slide 8: Advantages of using a ‘universal standard of care’

It prevents exploitation of vulnerable populations.

A fundamental ethical principle underlying the application of standards of care in health research with human participants is the avoidance of exploitation, particularly for communities who may be vulnerable because of their poverty or ethnicity. The issue of what standard to apply is especially complex when researchers conduct studies in international settings where health delivery systems are compromised because of lack of medical resources, including drugs, equipment, and personnel.

It is consistent with the investigator’s duty to beneficence.

The Belmont Report defined the four principles of bioethics, non-maleficence, beneficence, justice and autonomy that are used in deciding the ethical standards applied to research. The use of ‘a universal standard of care’ is consistent with the principle of “beneficence” that states that due to their participation in research, all possible benefits to participants should be maximized.

It complies with the strictest reading of the Declaration of Helsinki.

The Declaration of Helsinki (1996) states that “In any medical study, every patient – including those of a control group, if any -- should be assured of the best proven diagnostic and therapeutic method.”

It can build local healthcare capacity, raise awareness for services not currently available, and support community advocacy for provision of improved health infrastructure.
Determining the ‘standard of care’ for research depends on many factors—the budget and the availability of support from local governments, communities, and nongovernmental organizations. Research projects may not be able to compensate fully for the inadequacies in local health care systems but they can train health personnel, bring in new equipment, standardize care, and raise awareness for services not locally available. They can also assist local services to address the increased demand when previously undiagnosed health problems are identified. In addition, they can support community advocacy to demand that the government improve and expand the provision of services.

**Slide 9: Disadvantages of using a ‘universal standard of care’**

*Providing USC to control participants may make it impossible to answer a scientific question relevant to the host community.*

“All the guidelines that dissent from the Declaration of Helsinki prohibition on research using less than the worldwide best standard of care require that the purpose of the research must be to develop interventions that can be implemented in the host community, and thereby provide social benefit for it. Most clearly, the European Group on Ethics allows for exceptions to the requirement of using the worldwide best standard only when "...the primary goal of the clinical trial is to try to simplify or to decrease the costs of treatment for countries where the standard of treatment is not available for logistic reasons or inaccessible because of costs".

*Taken from: R K Lie, E Emanuel, C Grady, D Wendler, The standard of care debate: the Declaration of Helsinki versus the international consensus opinion, J Med Ethics 2004;30:190-193*  

*It imposes an ethical obligation on researchers to ensure that every participant has access to proven USC “prophylactic, diagnostic and therapeutic methods identified in the study” once the study is over.*

The Helsinki Declaration, requires that at the end of a study, ‘every patient in the study should be assured of access to the best proven prophylactic, diagnostic and therapeutic methods identified in the study’. The quality of healthcare available to community where research is occurring often declines at the end of a study. Large-scale intervention trials improve healthcare staffing, facilities, and access to therapeutics. Typically, those improvements are lost once a trial is completed. This raises important ethical questions:

- Do investigators and sponsors have an ethical obligation to maintaining improved ‘standard of care’ for participants after the trial?

- If a trial shows that an intervention is successful, is it ethically necessary to provide the intervention to participants on completion of the study?

- Does ethical responsibility lie solely with investigators and sponsors, or to local and national health authorities share in that responsibility?

**Slide 10: Advantages of using a ‘non-universal standard of care’**
Using “best a best locally available care” standard avoids offering “undue inducements” that can be ethically problematic.

Controversy begins to creep in when discussing medical or social service benefits beyond those required to conduct the trial, or providing benefits to trial participants that would not otherwise be locally available. Some argue that benefits beyond compensation for time and effort constitute “undue inducements” and are thus ethically problematic. Participants may be motivated to join the trial for access to an experimental treatment that they need, or in hope of continuing access if an experimental product is shown to be effective. Similarly, they may be motivated by a desire for better ongoing health care than is otherwise available locally, or simply by cash. Some prospective participants may want to participate—or may be pressured to participate—so that their communities receive collective benefits, such as improvements to the local health care infrastructure.

Taken from: Taken from: Global Campaign for Microbicides, Defining “Benefits” and “Standard of Care”. Found at: http://www.global-campaign.org/clientfiles/chapter7.pdf

Study participants will receive a ‘standard of care’ that can be sustained locally after the research is over.

The cost of evaluating a new intervention through clinical research is high; so high that it frequently is not be covered by many developing countries. In addition, many forms of interventions, especially new medicines and vaccines are costly to manufacture or purchase. Sustaining those interventions after a trial is completed is often not feasible for host communities.

It may be possible to answer a scientific question relevant to the host community that otherwise not be answered.

Although the interests of research participants should never be sacrificed for the sake of a scientific goal, some ethicists and researchers believe that it is possible to strike an appropriate balance between the interests of participants and communities in which they live, and the goal of society in advancing scientific knowledge. The measurement of absolute efficacy of a new and potentially more affordable and available intervention may be a more relevant research question for the host country than the comparison of a new intervention to an established effective treatment already available elsewhere.

Slide 11: Disadvantages of using a ‘non-universal standard of care’

Participants not receiving the best known interventions may suffer from preventable harm.

Virtually all experts believe that research would unethical if an established effective treatment known to prevent serious harm—such as death or irreversible injury—is available and can be provided. For instance, it is not ethically acceptable to compare a medically inferior therapeutic against thrombolytics [blood clot-dissolving agents] to assess survival after heart attacks. Even under these circumstances, however, exceptions may exist if an established effective treatment does not work in certain populations or has such serious side effects that cause some patients to refuse treatment.

Conforming to a universal standard avoids inconsistencies in the care provided among different sites in a multi-country study

“It can be argued that international research initiatives are legitimate vehicles through which global
inequalities in access to health care can be reduced. Conforming to a universal standard also avoids inconsistencies in the care provided among different sites in a multi-country study. To achieve the necessary numbers, trials frequently enroll participants in many countries and sites and then pool the data for analysis. If all decisions are negotiated locally based on local realities, different people in the same trial could receive different levels of care. The benefits, risks, burdens, and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. “

*Taken from: Global Campaign for Microbicides, Defining “Benefits” and “Standard of Care”. Found at: http://www.global-campaign.org/clientfiles/chapter7.pdf*

**Slide 12:** Use of placebos in research trials

Definition of “placebo”:

Merriam-Webster Dictionary defines a placebo as: (1) : a medication prescribed more for the mental relief of the patient than for its actual effect on a disorder (2) : an inert or innocuous substance used especially in controlled experiments testing the efficacy of another substance.

*Bioethicists have raised diverse concerns on the use of placebos in modern medicine and research.*

“Advocates of the position that placebo controls are unethical when alternative treatment exists are that investigators and IRBs do not have the right to decide the amount of discomfort or temporary disability a participant should ensure for the purpose of research and that disclosure of risks in the process of informed consent transfers the ethical burden to the research participant, thus inappropriately emphasizing the principle of autonomy over beneficence”.


**Slide 13:** International guidance on use of placebos

The Declaration of Helsinki (1964)

“The benefits, risks, burdens and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic or therapeutic method exists.”

The Declaration of Helsinki (2000)

World Medical Association revised its guidance on the use of placebo in 2000. According to the revision, “research trials might be ethically acceptable in certain circumstances. These were:

Where for compelling and scientifically sound methodological reasons its use was necessary to determine the efficacy or safety of a prophylactic, diagnostic, or therapeutic method; or

Where a prophylactic, diagnostic, or therapeutic method was being investigated for a minor condition and the patients who received placebo would not be participant to any additional risk of serious or irreversible harm.”

*Council for International Organizations of Medical Sciences (CIOMS 2002)*
“As a general rule, research participants in the control group of a trial of a diagnostic, therapeutic, or preventive intervention should receive an established effective intervention. In some circumstances it may be ethically acceptable to use an alternative comparator, such as placebo or "no treatment".

Placebo may be used:

- when there is no established effective intervention;
- when withholding an established effective intervention would expose participants to, at most, temporary discomfort or delay in relief of symptoms;
- when use of an established effective intervention as comparator would not yield scientifically reliable results and use of placebo would not add any risk of serious or irreversible harm to the participants.”


“Whether or not the use of a placebo is acceptable will depend on the nature of the disorder and the prevailing health care system. For example, when a treatment for onchocerciasis (river blindness) was being assessed in a clinical trial in the mid-1980s, the use of a placebo could be justified. At the time, two medicines were regularly used to treat onchocerciasis, diethylcarbamazine (DEC) and suramin. As both could cause frequent and often serious side effects, their use was restricted to selected patients. When clinical trials of a new medicine (ivermectin) were planned, a placebo rather than the local 'standard of care' was used because participants receiving either DEC or suramin could have been harmed. This approach was supported by the results from smaller scale pre-clinical trials (Phase I and II) which compared both ivermectin and DEC against a placebo. These demonstrated that ivermectin was as effective, and much safer, than DEC.9 However, in trials of a treatment for malaria, the use of a placebo is unlikely to be acceptable because the disease could be fatal if left untreated. Delegates agreed that use of placebos would have to be considered on a case by case basis.

Other situations in which it was suggested that the use of a placebo might be acceptable included:

- the treatment of non-infectious diseases, especially when the disease itself is of a mild and not permanently incapacitating nature, such as headache;
- a treatment being re-tested to account for regional variation in efficacy; and
- the treatment of acute diseases where the standard of care available in developed countries was not easy to attain in the health system settings of developing countries. In addition, where the use of that standard of care would preclude the possibility of detecting effects of interventions that were better than existing therapy but not as effective as the treatment available in developed countries.”

Slide 14: Unresolved issues regarding use of placebos

Several issues have not been satisfactorily resolved in international guidelines:

Early Phase Clinical Trials: Is it acceptable to use Placebo-controlled trials in early phase II trials in some circumstances?
Informed Refusal of Established Effective Therapy: Is it acceptable to conduct placebo-controlled trials when patients have provided an informed refusal of established effective therapy in conditions for which patients commonly refuse treatment and when withholding such therapy will not lead to undue suffering or the possibility of irreversible harm of any magnitude?

Cost Constraints or Limited Supply of Established Effective Therapy: Is it acceptable to conduct placebo-controlled trials in situations where established effective therapies are not available to the population under study due to cost constraints or limited supply?

**Slide 15:** Source of national guidance on ‘standards of care’ in India

INDIAN COUNCIL OF MEDICAL RESEARCH NEW DELHI (ICMR), Ethical Guidelines for Biomedical Research on Human Participants

Guidelines:

*With regard to ‘standard of care’*:

“The nature, magnitude, and probability of all foreseeable harms resulting from participation in a collaborative research programme should be specified in the research protocol and explained to the participants as fully as can be reasonably done. Moreover, the modalities by which to address these, including provision for **the best possible nationally available care** to participants who experience adverse reactions to a vaccine or drug under study, compensation for injury related to the research, and referral for psychosocial and legal support if necessary, need to be described.”

*On the use of placebos:*

“Use of a placebo in drug trials and sham surgery has come under severe scrutiny at the present age and requires careful consideration before approval.

Denial of the available treatment to control (placebo) group of patients is unethical.”

**Slide 16:** Main sources of international guidance on ‘standards of care’


The most recent document is downloadable at: [http://www.who.int/bulletin/archives/79(4)373.pdf](http://www.who.int/bulletin/archives/79(4)373.pdf)


The most recent document is downloadable at: [http://www.cioms.ch/guidelines_nov_2002_blurb.htm](http://www.cioms.ch/guidelines_nov_2002_blurb.htm)

Nuffield Council On Bioethics, The ethics of research related to healthcare in developing countries (2005)

Their most recent document is at: [http://www.nuffieldbioethics.org/fileLibrary/pdf/errhde_fullreport001.pdf](http://www.nuffieldbioethics.org/fileLibrary/pdf/errhde_fullreport001.pdf)

**Slide 17:** Healthcare context in India
• Half the population lives below poverty line of less than $1 a day severely limiting their access to healthcare.

• In India, only 17% of all health expenditure in the country is borne by the state, and 82% comes as ‘out of pocket payments’ by the people.

• Public spending on health is inadequate.

• Though the spending on healthcare is 6% of gross domestic product (GDP), the state expenditure is only 0.9% of the total spending.

• There are wide disparities in healthcare access, disease profile and life expectancy.

• The ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas. The ratio of doctors to population in rural areas is almost six times lower than that in the urban population. Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas.

• Examples of healthcare disparities are common: The Infant Mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population. A child in the ‘Low standard of living’ economic group is almost four times more likely to die in childhood than a child in the ‘High standard of living’ group. Children born in the tribal belt is one and half times more likely to die before the fifth birthday than children of other groups. A female child is 1.5 times more likely to die before reaching her fifth birthday as compared to a male child. A person from the poorest quintile of the population, despite more health problems, is six times less likely to access hospitalization than a person from the richest quintile. The delivery of a mother, from the poorest quintile of the population is over six times less likely to be attended by a medically trained person than the delivery of a well off mother, from the richest quintile of the population. A tribal woman is one and a half times more likely to suffer the consequences of chronic malnutrition as compared to women from other social categories.

• The public health system is resource constrained.

• The most vital unit of India’s public health infrastructure is a primary health centre (PHC). In a recent survey it was noticed that only 38% of all PHCs have all the essential manpower and only 31% have all the essential supplies (defined as 60% of critical inputs), with only 3% of PHCs having 80% of all critical inputs. Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, Cambodia)

Taken From: Milind Deogaonkar, Socio-economic inequality and its effect on healthcare delivery in India: Inequality and healthcare. Electronic Journal of Sociology (2004), ISSN: 1198 3655

Slide 18: Global health research context

• The highest 5% of the countries spend 4492% of the lowest quintile for healthcare. Annual per capita expenditure (APCE) varies from $4500 in US to less that $5 in some African nations
• In 1990’s, 90% annual global health expenditure was spent on 16% of population, that bore 7% of disease burden.

• The 10/90 gap: 90% of health research is on diseases that cause 10% of global disease burden

• Globally only 1% of new drugs discovered in past 25 years have been for tropical diseases


Slide 19: Controversies surrounding ‘standard of care’ in India

Among the many controversies surrounding “standard of care” in India:

• Difficulties in defining a local ‘standard of care’ in India.
• Need for “ratcheting-up” the current ‘standard of care’
• Need for research that is ‘responsive to the country’s health needs and priorities.

Slide 20: Difficulties in defining a local ‘standard of care’ in India.

• For many diseases ‘no treatment’ is the ‘standard or care’ for much of India.

• Universal access to healthcare is a norm in most of the developed countries and some developing countries. In India though, pre-existing inequality in the healthcare provisions is further enhanced by difficulties in accessing it.

• The issue of geographic distance is important in a large country like India with limited means of communication. Direct effect of distance of a given population from primary healthcare centre on the childhood mortality is well documented. Those who live in remote areas with poor transportation facilities are often removed from the reach of health systems.

• A different aspect of healthcare access problem is noticed in cases of ‘urban poor’. Though the healthcare facilities are overwhelmingly concentrated in urban areas, the ‘socio-economic distance’ prevents access for the urban poor. These socio-economic barriers include cost of healthcare, social factors, such as the lack of culturally appropriate services, language/ethnic barriers, and prejudices on the part of providers. All these factors lead to an inability to identify symptoms and seek appropriate care on the part of the poor.

• The third most important access difficulty is due to gender. It is said that health of society is reflected from the health of its female population. Gender discrimination makes women more vulnerable to various diseases and associated morbidity and mortality. Women are largely excluded from making decisions, have limited access to and control over resources, are restricted in their mobility, and are often under threat of violence from male relatives. In general an Indian woman is less likely to seek appropriate and early care for disease, whatever the socio-economic status of family might be. This gender discrimination in healthcare access becomes more obvious when the women are illiterate, unemployed, widowed or dependent on others.
Slide 21: Need to “ratchet-up” the current ‘standard of care’ in India

Many bioethicists agree with the view that researchers should improve the local ‘standard of care’ available during the conduct of research trials. The goal should be to move toward state-of-the-art care in the long run while doing as much as possible in the meantime.

As Shapiro and Benatar have written:

[Standard of care] “should include several interlinking features that would promote fairer distribution of burdens and benefits in both short and long term for participants in communities. First, research should be undertaken in the best interests of trial participants by involving them in decisions around research design and implementation. Second, the dignity of participants should be respected, wherever they are in the world. Third, consideration should be given to the broader community benefit that could be achieved by raising the standard of health care through partnerships created by the research endeavor. That the ideal of first world health care cannot be achieved immediately in developing countries should not be a deterrent to efforts to raise existing levels of care. By setting high ideals and working towards, them, the standard of care could be progressively ratcheted upwards.”


Slide 22: Need for research that is responsive to India’s health needs and priorities

Research in India should:

- Involve treatments that might foreseeably become available to local patients on a sustainable basis.
- Take into account whether prospective interventions are affordable locally.
- Explore treatment modalities that can be delivered within existing structures utilizing locally available healthcare staff and resources.

Slide 23: Take-home messages

- There is a need for more flexible and pragmatic approaches to research without compromising basic ethical tenets
- Guidelines require contextual interpretation considering standards available locally or in comparable health systems
- An attainable and sustainable national ‘standard of care’ is needed for India.

Case Study: Divide the class up into two groups and have them read and discuss the first study (20 minutes).
Case Study: Reproductive Health: Asian HIV Prevention Trial impasse

An international group of researchers and an Asian government enter into a collaboration to determine whether taking a tenofovir DF tablet (an antiretroviral agent) every day is safe and effective in preventing HIV infection. Nearly a thousand HIV negative women involved in full time sex work in this Asian country are to be enrolled in the trial to test whether taking a drug (tenofovir) will prevent HIV infection amongst healthy (uninfected) individuals if and when they are exposed to HIV. Participants are to receive one tablet of the drug, tenofovir, or a placebo daily for one year.

The Principal Investigators of this study (who are at the foreign university) made several trips to this Asian country while they were developing the study proposal. During these trips they met with a local sex workers’ union to better understand sex workers’ willingness to participate in such a trial and their concerns. At the first meeting, and at the subsequent meetings, several women expressed interest in the study as they felt they had limited access to HIV prevention methods – many women were engaging in sex work because other means of livelihood were not available to them. Many experienced violence by their clients. Further, younger women were constantly entering the trade.

However, several women also expressed serious concerns about the risks posed by the study. A key concern was, “What would happen to the women who became sick [infected with HIV] during the course of the study?” Also, what kinds of side effects did this medicine have and what would happen to women if they started to develop side effects after the one year duration of the study?

The researchers note that this is an HIV prevention trial; they will provide counselling to all participants regarding safer sex practices and the fact that the efficacy of tenofovir in preventing HIV is unknown. Any participant who tests positive will be referred to the public health program. The trial cannot provide life long Antiretroviral therapy to those who become infected during the course of the study. As far as safety is concerned, the drug tenofovir is currently being used to treat those who already infected with HIV. Its safety and efficacy among those who are uninfected is not known. The sponsor agency claims that it has sponsored small scale safety studies, which indicate that the drug is indeed safe.

The study protocols have been reviewed by the ethics committees of several participating universities and the National Ethics Committee in the Asian country. The local sex workers’ union has called on the Prime Minister to take action.

Questions:

1. Do you agree with the responses of the researchers? Why or why not?

2. Why do you think this study is being conducted in this Asian country?

3. Imagine that you are the Health Minister of this country and the Prime Minister has asked you for advice. What action would you advise and why? [Use the four key principles – and any others – to substantiate your decision.]
Module 5: Standard of Care
Case Study 1

4. Would your reasoning be different if the study was being undertaken by local researchers (that is nationals of this Asian country) and funded by a national sponsoring agency?

Based on Tenofovir trial in Cambodia as reported by:
Joe Thomas, Cambodian HIV Clinical Trial impasse: UNAIDS mediation is essential in AIDS-ASIA Yahoo Groups.


Case study prepared by: Dr. Suneeta Krishnan, Asst. Professor, UCSF and IIM Bangalore, for UCB/SF Fogarty Ethics Training Project
Case Study: Testing a New HIV Vaccine

Viravax, a UK-based company has developed a vaccine against HIV that appears promising. Animal studies were very successful and phase I and phase II trials demonstrated that the vaccine was remarkably safe and that it produced significant antibody levels in essentially all of the volunteers. The company now wishes to begin phase III trials in Ho Chi Minh City, Vietnam where previous surveillance has identified a cohort of intravenous drug users (IDU) with a high rate of conversion to HIV-1. Such a study could be completed in two years. The Vietnamese Government has expressed interest in having the study conducted in their country and begins negotiations with Viravax. The vaccine, which is specifically directed against the strain that predominates in the Vietnamese IDU population, will be provided free by Viravax. Viravax will also cover the cost of conducting the study, which will be carried out by the Vietnam Vaccine Institute. In addition to the study costs, the company will provide all of the laboratory equipment necessary to conduct the studies, ten computers for the Institute, and two vehicles to visit the study sites. The company agrees that if the vaccine proves effective it will be given free of charge to the IDU population of the city and at cost to the country for five years.

This will be a randomized double blind prospective study with one group receiving the test vaccine and the other group receiving a placebo. All potential participants will be tested for HIV prior to being enrolled in the study, and if they are HIV+ they will be referred to one of the municipal hospitals of the Ho Chi Minh City Corporation. The company and the Institute also agree that anyone who converts to HIV+ during the study will be referred to one of the Municipal Corporation hospitals to be treated by the standard method published in the Ministry of Public Health document, "Guidelines for the Clinical Management of HIV Infection in Children and Adults." This means that all infections are treated but patients are not given anti-retroviral drugs, including AZT, or protease inhibitors. If there are any changes to the standard therapy recommended by the government, all previous (and future seroconvertors) will be switched to the new therapy. The Municipal Corporation will provide treatment for the lifetime of the seroconverted participants. Individuals can drop out at any time without fear of prejudice.

The informed consent process will have two stages. First, potential participants will be briefed about the study, including an explanation of the experimental nature of the vaccine and the treatment policy. Two days following the initial briefing the individuals will return to the Institute where they are given a brief oral and written exam to see if they fully understand the study and their rights. They will only be enrolled if they pass the test. The study is submitted to the Ethical Review Board of the Institute and to a firm that conducts ethical reviews for companies in the private sector who wish to conduct research on human subjects. The protocol is also reviewed informally and commented on by UNAIDS at the request of the Ministry of Public Health Technical Subcommittee on HIV Vaccines. The Subcommittee approves the protocol and forwards it to the Ministry of Public Health Ethical Committee. All review boards approve the study.

After the study has begun, an article condemning the study appears in an AIDS activist group’s publication. The group objects to the fact that the study does not provide state-of-the-art care for seroconverting individuals. They argue that the only reason the study is being conducted in
Module 5: Standard of Care
Case Study 2

Vietnam is because it is much less expensive to do there, as triple therapy is not required (which would be necessary if the study was conducted in the UK). They feel that the study (as presently designed) would never be approved by a UK government committee or a university ethical review committee in the UK. Viravax counters that the use of state-of-the-art therapy would in itself be unethical because the treatment regimen would not be sustainable in Vietnam and only one small group would have access to this therapy. In addition, the physicians in Vietnam would be unfamiliar with the therapy and unaware of all the possible side effects. And lastly, by offering the best care available in the world, the study would be giving an unfair inducement to participate.

Questions:

1. Is the study unethical because participants are not being offered the best care available in the world if they should become HIV+?

2. Would it be unethical to offer state-of-the-art care to seroconvertors even if the care was not available in Vietnam, and was unlikely to be available within the near future except to the very wealthy?

3. Is there any compromise position that may be acceptable to both parties?

4. If the developer of the vaccine was a Vietnamese company who wished to conduct the study in its own country, would the use of "best available or standard local therapy" for seroconvertors be viewed differently? What are the implications if the standards are different? The same?

5. Should the vaccine be tested if it is presently unaffordable to the country for wide distribution?

6. Are there any other services that should be provided to the IDU population?

Source: Program on Ethical Issues in International Health Research, Department of Population and International Health, Harvard School of Public Health and Achutha Menon Centre for Health Science Studies, Thiruvananthapuram, India

Note: Cases are fictional, but based on real events. All individual and organization names have been changed.
Standards of Care in Health Research

Basic training on Ethical issues in Health Research

Module 5
Module Objectives

- Explore different approaches for evaluating standard of care (SOC) in health research and discuss the advantages and disadvantages of each.
- Address the special ethical dilemmas involving use of placebos in clinical trials.
- Identify sources for national and international guidance.
- Discuss controversies surrounding SOC in India.
Standard of Care (SOC)

Definitions:

- Standard of Care
- Universal Standard of Care (USC)
- Non-universal Care (NUC)
“In any medical study, every patient – including those of a control group, if any -- should be assured of the best proven diagnostic and therapeutic method.”

Declaration of Helsinki (1996)
Principle II-3
Challenges of Applying Principle II-3

- A strict interpretation of II-3 would exclude almost all controlled trials whether the control group received no treatment (with or without a placebo) or a comparison treatment which was less than the optimal treatment available in a developed country.
Clarifying Principle II-3

CIOMS guidelines:

The ethical principals in the Declaration of Helsinki can “be effectively applied, particularly in developing countries given their socioeconomic circumstances, laws, regulations and executive and administrative arrangements.”
Approaches to Evaluating ‘Standard of Care’

Research can be evaluated against a:

- ‘Universal standard of care’ equivalent to the best current method of treatment available anywhere in the world for a particular disease or condition.

- ‘Non-universal standard of care’ equivalent to the best proven diagnostic and therapeutic method available in the country where the research is being conducted.
Advantages of a “Universal Standard of Care”

- It prevents exploitation of vulnerable populations.
- It’s consistent with the investigator’s duty to beneficence.
- It complies with the strictest reading of the Declaration of Helsinki.
- It can build local healthcare capacity, raise awareness for services not currently available, and support community advocacy.
Disadvantages of a “Universal Standard of Care”

- Providing USC to control participants may make it impossible to answer a scientific question relevant to the host community.

- It imposes an ethical obligation on researchers to ensure that every participant has access to proven USC “prophylactic, diagnostic and therapeutic methods identified in the study” once the study is over.”
Advantages of a ‘Non-universal Standard of Care’

- Using “best a best locally available care” standard avoids offering “undue inducements” that can be ethically problematic.

- Study participants receive a standard of care that can be sustained locally after the research is over.

- It may be possible to answer a scientific question relevant to the host community that otherwise might not be answered.
Disadvantages of a ‘Non-universal Standard of Care’

- Participants not receiving the best known interventions may suffer from preventable harm.

- Conforming to a universal standard avoids inconsistencies in the care among different sites in a multi-country study.
Use of Placebos in Trials

- Definition of “placebo”

- Bioethicists have raised diverse concerns on the use of placebos in modern medicine and research
International Guidance on Placebos

- The Declaration of Helsinki (1964)
- The Declaration of Helsinki (Revision of 2000)
- Council for International Organizations of Medical Sciences (CIOMS 2002)
Unresolved Issues Regarding Placebos

Several issues have not been satisfactorily resolved in international guidelines:

■ Use of placebos in Early Phase Clinical Trials

■ Use of placebos in the case of informed refusal of established effective therapy

■ Use of placebos where there are cost constraints or limited supply of established effective therapy
Guidance on ‘Standards of Care’ in India

Indian Council of Medical Research Ethical Guidelines for Biomedical Research on Human participants:

- ‘Standard of care’
- On the use of placebos
Main sources of International Guidance


- Nuffield Council On Bioethics, The ethics of research related to healthcare in developing countries (2005)
Health Care Context in India

- Half the population lives below poverty line of less than $1 a day--severely limiting access to healthcare.
- Public spending on health is inadequate.
- There are wide disparities in healthcare access, disease profile, and life expectancy.
- The public health system is resource constrained.
Global Health Research Context

- The highest 5% of the countries spend 4492% of the lowest quintile for healthcare. Annual per capita expenditure (APCE) varies from $4500 in US to less that $5 in some African nations.

- In 1990’s, 90% annual global health expenditure was spent on 16% of population, that bore 7% of disease burden.

- Ninety percent of health research is on diseases that cause 10% of global disease burden.

- Globally only 1% of new drugs discovered in past 25 years have been for tropical diseases.
Controversies Surrounding ‘Standard of Care’ in India

- Difficulties in defining a local ‘standard of care’ in India
- Need for “ratcheting-up” the current ‘standard of care’
- Need for research that is ‘responsive to the country’s health needs and priorities’
Difficulties in Defining ‘Standard of Care’ in India

- For many diseases ‘no treatment’ is the ‘standard or care’ for much of India.
- Determining the appropriate ‘standard of care’ in India is difficult.
- Provision of only best available methods would exclude incremental improvements in healthcare.
Need to “Ratchet-Up” ‘Standard of Care’ in India

Step-wise Improvement

(B)
Current Practice

(B+)
Improved Care

(A)
Best Care

Direct move from Current to Best care
Need for Research that is Responsive to India’s health Needs and Priorities

Research in India should:

- Involve treatments that might foreseeably become available to local patients on a sustainable basis.

- Take into account whether prospective interventions are affordable locally.

- Explore treatment modalities that can be delivered within existing structures utilizing locally available healthcare staff and resources.
Conclusions

- There is a need for more flexible and pragmatic approaches to research without compromising basic ethical tenets

- Guidelines require contextual interpretation considering standards available locally or in comparable health systems

- An attainable and sustainable national standard is needed for India
Module 6
Integrity in Research: Publication, Authorship and Conflict Of Interest

By the end of the day the participants will be able to:

- Understand the importance and core values of integrity in research.
- Recognize the issues and challenges of publication and authorship and be able to identify sources of guidance on the participant.
- Define types of misconducts in research and strategies to avoid and rectify them.
- Understand the concept of conflict of interest (COI) and be able to identify and deal with it in research and ethical review of studies.

Preparatory Reading:


Handouts:

- Case study 1
- Case study 2

Training Schedule:

Time: 1 hour 30 minutes (45 minutes for case studies and 45 minutes for presentation and discussion)

Facilitator Notes:

Case Study: Divide the class up into two groups and have them read and discuss the first case study (20 minutes).

Presentation (45 minutes):

Slide One: Module Title

Slide Two: Presentation Overview

Slide Three: Importance of Integrity in Research

The scientific research enterprise, like other human activities, is built on a foundation of trust. Scientists trust that the results reported by others are valid. Society trusts that the results reflect an honest attempt by scientists to describe the world accurately & without personal bias. This trust will endure only if the scientific community devotes itself to exemplifying and transmitting the values associated with ethical scientific conduct.

Slide Four: Integrity in Research: Core Values:

Explain and discuss at least four core values:
**Honesty** would include faithful representation of data and results, appropriate crediting of one's sources, recognition of colleagues and assistants who have participated in the research or scholarly activities, and acceptance of responsibility for the quality of work to which one's name is attached. Academic honesty also includes the obligation to correct errors in published data if they are discovered and report activities which one believes to violate the ethical standards of the academic and scientific communities.

**Scepticism** is the maintenance of an inquiring attitude or state of mind that questions the veracity of claims unless they can be empirically tested.

**Fairness** dictates that where there are differences of opinion or competing scientific explanations, the range of perspectives should be presented in a balanced way.

**Collegiality** denotes the quality of being able work toward a common purpose with others in the scientific enterprise while respecting each other's abilities and motivations.

**Openness** means that all interested persons shall have freedom of access to the underlying data, to the processes, and to the final results of research.

**Slide Five: Integrity in Research: Institutional Environment**

For ensuring integrity of good science, the institutions must have social space for personal initiative & creativity; time for ideas to grow to maturity; openness to debate and criticism; hospitality toward novelty; and respect for specialized expertise.

“Institutions seeking to create an environment that promotes responsible conduct by individual scientists and that fosters integrity must establish and continuously monitor structures, processes, policies, and procedures that: provide leadership in support of responsible conduct of research; encourage respect for everyone involved in the research enterprise; promote productive interactions between trainees and mentors; advocate adherence to the rules regarding all aspects of the conduct of research, especially research involving human participants and animals; anticipate, reveal, and manage individual and institutional conflicts of interest; arrange timely and thorough inquiries and investigations of allegations of scientific misconduct and apply appropriate administrative sanctions; offer educational opportunities pertaining to integrity in the conduct of research; and monitor and evaluate the institutional environment supporting integrity in the conduct of research and use this knowledge for continuous quality improvement. Leadership by individuals of high personal integrity helps to foster an environment in which scientists can openly discuss responsible research practices in the face of conflicting pressures.”

*Taken from: Integrity in Scientific Research: Creating an Environment That Promotes Responsible Conduct (2002). Board on Health Sciences Policy (HSP). Institute of Medicine*

**Slide Six: Guidance for protection and promotion of integrity in research**

The following sources are available for guidance on promotion of integrity in research:


Researchers have a right as well as a responsibility to refrain from undertaking or continue undertaking any research that contravenes ethical guidelines, violates the integrity of research and/or compromises their autonomy in research, including design methodology, analysis and interpretation of findings and publication.

*Taken from: Section III 2. Protection and promotion of integrity in research*

Researchers should undertake only such research that will be useful to society or to the furtherance of knowledge on participant; make all necessary efforts to bring the research and its findings to the public domain in an appropriate manner; and not to undertake secret/classified research, any secret assignment under the garb of research nor research whose findings are to be kept confidential.

*Taken from: Section III 2.2, 2.3. Protection and promotion of integrity in research*

Researchers should also anticipate and guard against possible misuse and undesirable or harmful consequences of research; take reasonable corrective steps when they come across misuse or misrepresentation of their work; ensure that there is honesty and transparency at every stage of research.

*Taken from: Section III 2.4, 2.5. Protection and promotion of integrity in research*

Researchers should ensure that there is no fabrication, falsification, plagiarism, conflict of interest or other unethical practices at any stage of the research; all parties involved in research and dissemination of its findings should inculcate and practice sensitivity and respect for culture and other aspects of the group or community studied. Peer review should be an essential part of every research endeavour or initiative, and should be sought at various stages of research.”

*Taken from: Section III 2.6, 2.7, 2.9. Protection and promotion of integrity in research*

It is a duty of researcher to participate in ethics review, peer review, to be a referee, to act as an editor; and in these functions, there is a duty to uphold integrity of self, science and society

*Slide 12: Ethical Guidelines for Social Science Research in Health, cont.*

Excerpts from Ethical Guidelines for Social Science Research in Health:

On reporting of research and its results:

III.5.1. Reporting of research and its results is the right as well as duty of every researcher and institution that conducted the study. When they agree to delegate this responsibility to funder(s)/sponsor(s) or any other individual(s)/organisation(s), they should do it only if they have
received mutually agreed and expressed commitment to publish/disseminate the results/report within a stipulated period.

On the unconditional nature of reporting required:

II.5.2. The results should be reported irrespective of whether they support or contradict the expected outcome(s).

On disclosure of funding:

II.5.2. Researchers should also disclose in their publications, the source(s) of funding and sponsors, if any, unless there is a compelling reason not to do so.

On dissemination of results:

III.5.4. Researchers should avoid dissemination of the results of research before they are peer-reviewed or published in appropriate journals. When such results are disseminated through the popular media, extra care should be taken to ensure that even those media persons not specifically trained in social science and health issues and research, are able to comprehend the limitations and implications of research results. Journalists and the media that publish these research results have a responsibility to do so truthfully and honestly.

Slide 13: Uniform Requirements for Manuscripts Submitted to Biomedical Journals

Excerpts from Ethical Guidelines for Social Science Research in Health:

On Authorship:

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the content.

Authorship credit should be based only on substantial contributions to 1) conception and design, or analysis and interpretation of data; and to 2) drafting the article or revising it critically for important intellectual content; and on 3) final approval of the version to be published. Conditions 1, 2, and 3 must all be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. General supervision of the research group is not sufficient for authorship. Any part of an article critical to its main conclusions must be the responsibility of at least one author.

Editors may ask authors to describe what each contributed; this information may be published.

On Attribution:

At an appropriate place in the article (the title-page footnote or an appendix to the text; see the journal's requirements), one or more statements should specify 1) contributions that need acknowledging but do not justify authorship, such as general support by a departmental chair; 2) acknowledgments of technical help; 3) acknowledgments of financial and material support, which should specify the nature of the support; and 4) relationships that may pose a conflict of interest (see Conflict of Interest).

Persons who have contributed intellectually to the paper but whose contributions do not justify authorship may be named and their function or contribution described-for example, "scientific
adviser," "critical review of study proposal," "data collection," or "participation in clinical trial." Such persons must have given their permission to be named. Authors are responsible for obtaining written permission from persons acknowledged by name, because readers may infer their endorsement of the data and conclusions.

Technical help should be acknowledged in a paragraph separate from that acknowledging other contributions.

**Slide 14:** Uniform Requirements for Manuscripts Submitted to Biomedical Journals, cont.

Excerpts from Ethical Guidelines for Social Science Research in Health:

*On redundant or duplicate publications:*

Readers of primary source periodicals deserve to be able to trust that what they are reading is original unless there is a clear statement that the article is being republished by the choice of the author and editor. The bases of this position are international copyright laws, ethical conduct, and cost-effective use of resources.

Most journals do not wish to receive papers on work that has already been reported in large part in a published article or is contained in another paper that has been submitted or accepted for publication elsewhere, in print or in electronic media. This policy does not preclude the journal considering a paper that has been rejected by another journal, or a complete report that follows publication of a preliminary report, such as an abstract or poster displayed for colleagues at a professional meeting. Nor does it prevent journals considering a paper that has been presented at a scientific meeting but not published in full or that is being considered for publication in a proceedings or similar format. Press reports of scheduled meetings will not usually be regarded as breaches of this rule, but such reports should not be amplified by additional data or copies of tables and illustrations.

When submitting a paper, the author should always make a full statement to the editor about all submissions and previous reports that might be regarded as redundant or duplicate publication of the same or very similar work. The author should alert the editor if the work includes participants about which a previous report has been published. Any such work should be referred to and referenced in the new paper. Copies of such material should be included with the submitted paper to help the editor decide how to handle the matter.

*On identifying information:*

Patients have a right to privacy that should not be infringed without informed consent. Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published.

Identifying details should be omitted if they are not essential, but patient data should never be altered or falsified in an attempt to attain anonymity. Complete anonymity is difficult to achieve, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity.
The requirement for informed consent should be included in the journal's instructions for authors. When informed consent has been obtained it should be indicated in the published article.

On ethical standards followed:

When reporting experiments on human participants, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional or regional) and with the Helsinki Declaration of 1975, as revised in 1983. Do not use patients' names, initials, or hospital numbers, especially in illustrative material. When reporting experiments on animals, indicate whether the institution's or a national research council's guide for, or any national law on, the care and use of laboratory animals was followed.

**Slide 15: Scientific Misconduct: Plagiarism**

Plagiarism includes both the theft or misappropriation of intellectual property and the substantial un-attributed textual copying of another's work. It does not include authorship or credit disputes.

The theft or misappropriation of intellectual property includes the unauthorized use of ideas or unique methods obtained by a privileged communication, such as a grant or manuscript review.

Substantial un-attributed textual copying of another's work means the un-attributed verbatim or nearly verbatim copying of sentences and paragraphs which materially mislead the ordinary reader regarding the contributions of the author.

From Office of Research Integrity (ORI) Newsletter, Vol 3, No. 1, December 1994

Example:

Gerald I. August was an associate professor of psychiatry at the University of Minnesota, who copied the text on interventions for conduct disorders from another scientist’s NIH grant application that he had obtained as a peer reviewer, into his own NIH application, for which the other scientist became a reviewer. The respondent claimed that he had made an error, failing to keep track of the source of his notes, but the university and ORI found plagiarism on his part. He was required in 1994 to certify future applications and not serve as a advisor for 5 years.


**Slide 16: Scientific Misconduct - Fabrication**

"Fabrication is making up data or results and recording or reporting them."

U.S. Office of Science and Technology Policy

Example:

South Korea's Hwang Woo-suk was feted as a national hero when, in 2004, his research team said it had successfully cloned a human embryo and produced stem cells from it, a technique that could one day provide cures for a range of diseases.

Dr Hwang was in March fired from his professorship at Seoul National University (SNU) when it was found that he faked data for two landmark pieces of research into cloning human stem cells.
Slide 17: Scientific Misconduct - Falsification

“Falsification is manipulating research materials, equipment, or processes, or changing or omitting data so as to misrepresent the research.”

Taken from: Mann et al. Education in the Responsible Conduct of Research
Presented at the Annual Meeting of the
Association of Chairs of Departments of Physiology

Example:

A breast cancer researcher from South Africa admitted to falsifying the results of a study that showed high-dose chemotherapy followed by bone marrow transplants benefits patients with advanced breast cancer. A team of American scientists became suspicious about the results of Dr. Werner Bezwoda
Professional Standards and Conventions

Susan Wallace is a post-doctoral fellow preparing her first manuscript for publication as first author. Her goal of preparing a high quality paper seems to be shared by her mentor, Dr. Richards, and everyone in the lab in her department.

As part of the evidence supporting the fact that her work has been carried out in the part of the nervous system she claims, she has photographed an electrical record, which is a hallmark of this region. Unfortunately, even Beverly, the technician who is the photographic wizard, cannot produce a manuscript-quality black and white photograph that clearly depicts the record that is apparent in shades of brown to the naked eye. The best she can do is a few black dots at key places. Susan shows the disappointing results to Dr. Robinson, an assistant professor in her department. After some consideration, Dr. Robinson whips out her black pen and straight edge and connects the dots, creating a figure that accurately duplicates the record that could not be photographed. The result is exactly what is desired and when Susan takes the photographs for the manuscript to Dr. Richards, he is pleased. Familiar with the difficulties in getting the one photograph, he asks how the excellent results were obtained and chuckles when Susan explains Dr. Robinson’s handiwork.

The manuscript is submitted and accepted after minor revisions. Susan is somewhat uncomfortable even though she knows the data were not misrepresented, because she also knows that no other investigator could duplicate the figure. She knows this is a “minor detail” in the larger picture and does not wan to be labelled as a “Goodie Two Shoes” by her mentor and colleagues.

1. Provide an ethical analysis of this situation.
2. Has anyone done anything wrong? If so, who?
3. What, if anything, is the act (or are the acts) of wrongdoing?
4. What should be the response on the part of individuals who perceive the conduct as ethically wrong?
5. Is a conflict between self-interest and thoroughly honest behaviour a genuine ethical dilemma?

Source: Achutha Menon Centre for Health Science Studies, SCTIMST, Thiruvananthapuram, India
Smudged Data

Jane Doe, a post-doctoral fellow, is a well-trained researcher. She has begun working in the laboratory of Dr. Jones, whose research area is similar to her own.

Jane records her data into a bound notebook, but on one Friday afternoon in June, she runs into a snag. She has reserved the only widget Colorimeter in the building from 3:30 to 4:15 PM, and knows this is the last available time for two weeks. Her tissue samples, which take a week to prepare, are ready. She races to the spectrophotometer, only to discover that she has forgotten to bring her notebook. If she goes back to get it, she will not have sufficient time to read her samples. Instead, she grabs a handful of paper towels on which she records her results.

Since Jane has an appointment outside the lab, she leaves the towels on her lab bench and goes home for the weekend. When she arrives on Monday morning, she notes that: 1) she has not dated her results; 2) some of the data has been smudged; and 3) there are several other bits of paper on the bench with notations from past experiments.

Jane deduces which results are from the previous Friday’s experiments and records them in her notebook under Friday’s dates, discarding the paper towels. When the experimental series has been completed, she analyzes her results and finds that they are excellent support for the hypothesis on which she has based the NIH grant proposal she is writing. However, much of the data’s unique aspect hinges on her results from the Friday experiments described above. She discusses her concerns with her mentor, Dr. Jones, who has not been involved in the experiments but who is a co-investigator on her grant. Dr. Jones urges Jane to submit the analysis in question with her preliminary results. He presents the rationale that: 1) she will confirm the results in later experiments; 2) her work is so good that it is important to obtain funding; and 3) if she does not obtain research funding, it may not be possible for him to retain her in the laboratory.

Integrity:

1. Are there any ethical problems in the above picture?
2. If so, what is the wrongdoing, and who has done it?
3. What were Jane Doe’s options in this situation?
4. Did Dr. Jones offer ethically sound advice? If not, what should he have suggested?

Source: Achutha Menon Centre for Health Science Studies, SCTIMST, Thiruvananthapuram, India
Module 6: Integrity in Research

Case Study 3

Authorship

Pat Jones and Chris Brown are both Associate Professors at a large research university. They are collaborating on a project that combines Pat’s expertise as a molecular biologist and Chris’s skills as a clinician.

As they are conferring over the third draft of the manuscript, Pat states that David Smith, the researcher who supplied the antibody used in this study, has called and expects to be included as an author. Pat explains that a significant amount of time and effort went into collecting and purifying the antibody and that Smith, who is up for tenure next year and needs publications in reviewed journals, is willing to read and comment on their manuscript.

Chris objects because this was not an initial condition of providing the antibody and especially because this is not an area of research with which David Smith is at all familiar. Chris does not believe Smith will be able to contribute significantly to the manuscript but will slow down the submission and publication process. In addition, Chris, who was the second author on the paper and who is also coming up for tenure, feels that credit for his contribution to the manuscript will be lessened by adding a third author.

Questions:

1. Were the contributions of David during the research and promise to contribute by reading and commenting on manuscript sufficient to deserve authorship?
2. Should they agree to give him authorship?
3. If yes, under what conditions they should allow him to have authorship?

Source: Achutha Menon Centre for Health Science Studies, SCTIMST, Thiruvananthapuram, India
Presentation Overview

- Integrity in research
- Guidance on research integrity
  - Ethical Guidelines for Social Science Research in Health
  - Vancouver Guidelines
- Scientific misconduct – plagiarism, fabrication, and falsification
- Conflict of Interest
Importance of Integrity in Research

- The scientific enterprise is built on a foundation of trust. Society assumes scientists describe the world accurately & without personal bias.

- This relationship has contributed to a period of unparalleled scientific productivity.

- Faith in science will endure only if scientists devote themselves to ethical conduct.
Integrity in Research: Core Values

Certain core values are important in research:

- honesty
- skepticism.
- fairness
- collegiality
- openness

(From: “On being a scientist: Responsible conduct in research”. National Academy of Sciences, 1997: Washington DC)
Integrity in Research: Institutional Environment

Integrity in research requires:

- social space for personal initiative & creativity.
- time for ideas to grow to maturity.
- openness to debate and criticism.
- hospitality toward novelty.
- respect for specialized expertise.
Guidance for Protection and Promotion of Integrity in Research

Guidance for promoting integrity in research is available in:

- **Ethical Guidelines for Social Science Research in Health.** The Indian National Committee for Ethics in Social Science Research in Health (NCESSRH). 2000.

Ethical Guidelines for Social Science Research in Health

“Researchers have a right as well as a responsibility, to refrain from undertaking or continue undertaking any research that contravenes ethical guidelines, violates the integrity of research and/or compromises their autonomy in research, including design methodology, analysis and interpretation of findings and publication.”
Ethical Guidelines for Social Science Research in Health, contd.

Researchers should:

- only undertake research that will be useful to society or to the furtherance of knowledge on the participant.

- make all efforts to bring findings to the public domain in an appropriate manner.

- NOT undertake secret or classified research or studies whose findings are to be kept confidential.
Ethical Guidelines for Social Science Research in Health, contd.

Researchers should:

- anticipate and guard against possible misuse and undesirable or harmful consequences of research.
- take reasonable corrective steps when they come across misuse or misrepresentation of their work.
- ensure that there is honesty and transparency at every stage of research.
Ethical Guidelines for Social Science Research in Health, contd.

Researchers should:

- ensure that there is no fabrication, falsification, plagiarism, conflict of interest or other unethical practices at any stage of the research.

- disseminate findings with sensitivity and respect for the culture and other aspects of the group or community studied.

- submit to adequate peer review.
Ethical Guidelines for Social Science Research in Health, contd.

- It is the duty of researcher to:
  - participate in Ethics and Peer review
  - act as a referee.
  - act as an editor.

- In these functions, they should uphold integrity of self, science and society.
Ethical Guidelines for Social Science Research in Health, contd.

- Reporting of research and its results is the right as well as duty of every researcher.
- Results should be reported irrespective of whether they support or contradict expected outcomes.
- Researchers should disclose sources of funding and sponsors.
- Investigators should avoid dissemination of results of research prior to publication.
Uniform Requirements for Manuscripts Submitted to Biomedical Journals

- Authorship is based on all of the following:
  - substantial contributions to conception, design, analysis and acquisition or interpretation of data;
  - drafting the article or revising it critically for important intellectual content; and
  - final approval of the version to be published.

- All contributors who do not meet the criteria for authorship should be listed in an acknowledgments section.
Uniform Requirements for Manuscripts Submitted to Biomedical Journals, cont.

Other publication guidelines:

- Authors should not submit a redundant or duplicate publication that overlaps substantially with one already published.

- No identifying information should appear in written descriptions, photographs, and pedigrees without written informed consent from study participants.

- Authors should indicate whether study procedures followed were in accordance with international ethical standards and the responsible committee on human or animal experimentation.
Scientific Misconduct: Plagiarism

- Claiming ideas or data of another as one’s own, or using those ideas or data without appropriate credit or compensation
- Falsely attributing authorship
- Using the work of students/subordinates in papers
- Using input of supervisor without proper acknowledgement
- Improper citing of sources
Scientific Misconduct - Fabrication

Fabrication may include:

- Invention of data or results.
- Inflation of respondent or participant numbers.
- Padding of references in a publication.
Scientific Misconduct - Falsification

Falsification may include:

- misrepresentation of scientific credentials.
- changing or wrongly reporting data or results.
- omission of critical data.
- repeating an experiment until the “right results” are achieved.
Other Types of Misconduct

- Recklessness and Negligence
- Malicious accusations
- Violations of due process
- Reprisals against whistleblowers
- Cover-up of Misconduct
Conflicts of interest in the conduct of scientific research can be financial or non-financial:

- Financial - An investigator’s monetary interest causes bias in the design, conduct or reporting of research.

- Non-financial – When factors like competition for research funding, previous disagreements between investigators, and opportunities for career advancement lead to bias in design, conduct or reporting of research.
Conflict of interest - Scope

Conflicts of interest can involve individuals, institutions, or Ethics Review Committees. It may occur when:

- Investigators have financial interests in sponsors, economic interests, or family relationships that bias their judgment.
- Institutions benefit financially from a successful outcome.
- Ethics Review Committee members review member’s research, are biased against a researcher or project, or have personal relationships with the investigator or project staff.
Identifying Conflict of Interest

Tests for Conflict of Interest:

1. Whether an outside observer would question the ability of the individual to make a proper decision despite possible considerations of private or personal interests.

2. Whether the public would believe that the trust relationship between the relevant parties could reasonably be maintained if they had accurate information on the potential sources of COI.
Conflict of Interest - Disclosure

- Investigators have an obligation to disclose Conflict of Interest to:
  - Study participants.
  - Sponsoring Intuitions.
  - Ethics Review Committees.
  - Journals during publication.

- Ethics Review Committee members with financial interests, relationships or commitments that would impair their ability to make impartial judgments should recuse himself/herself from deliberations.
Protecting against Conflict of Interest

In cases of significant Conflict of Interest the ethics review committee may require a researcher to:

- abandon conflicting interest(s).
- give up decision-making position in research.
- withdraw from the research.

In other cases they may require researcher to:

- disclose COI while monitoring closely.
- make the ethics review and monitoring process more stringent.
Module 7
Risks and Benefits: Analysis and Safety Monitoring

By the end of the day the participants should be able to:

- Identify the various types of risks and benefits involved in research and how the ethical principles are applied to evaluate them.
- Define the concept of minimal risk within research.
- Identify methods to anticipate and mitigate risk within research.
- Understand the burden of risk borne by vulnerable populations.
- Identify the components of a Data Safety Monitoring Plan.

METHOD:

Time: 1 hour 30 minutes (45 minute presentation hour presentation followed by 45 minute discussion)

MATERIALS:

✓ PowerPoint Presentation

PRESENTATION:

Facilitator’s notes:

Slide 1: Module Title
Slide 2: Presentation Overview
Slide 3: Risk/Benefit Analysis

“Every medical research project involving human participants should be preceded by careful assessment of predictable risks and burdens in comparison with foreseeable benefits to the participant or to others.”

From: Ethical Principles for Medical Research Involving Human Participants. Declaration of Helsinki. World Medical Association

Mitigating risks to participants in research and enhancing benefits (direct to participants and to science) constitute one of the core objectives of the ethics review. Thus, the objectives of the ethics review, relevant to topic are: ensuring scientific merit of the research; identifying probability and magnitude of all potential risks and benefits; assessment of risks and benefit ratio; determining whether the method of research proposed would effectively minimise harms and maximise benefits and determining the method and periodicity of monitoring of research process and results in order to ensure continued balance between the risks and benefits.

Slide 4: Ethical Principles underlying Risk/Benefit Analysis

Briefly discuss principles of nonmaleficence and beneficence, justice, privacy and confidentiality in relation to evaluating risks and benefits in research projects.

Principles underlying Risk/Benefit analysis:

Ver may07
1. **Nonmaleficence** requires that we not intentionally create a needless harm or injury to the patient, either through acts of commission or omission.

2. **Beneficence** requires that investigators provide a benefit to the participants and take positive steps to prevent and to remove harm.

3. **Justice** is a duty to treat all fairly, distributing the risks and benefits equally.

4. **Confidentiality** requires that researchers respect privacy of information and action.

Some important points that could be raised while explaining application of these principles are:

Research with and without direct benefits to participants; potential benefit to the society and the advancement of scientific knowledge that potentially benefit the society; benefits to others – institutions, community, etc.; obligation to maximise benefits and minimise risks; the issue of reasonable of risks in relation to benefits; make very clear that welfare of participants take precedence over the interests of science and society; fairness of selection of participants and ensuring that the vulnerable people are not made to bear all or more risks; obligation to responding to the health needs of the population where study is conducted; the level of confidentiality provided should be commensurate to the risks involved; etc.

**Slide 5**: Six types of harm research can cause

Explain at least six types of potential harms that research can cause:

1. Physical Harm;
2. Psychological Harm;
3. Social Harm (Effect on one’s interaction or relationship with others – e.g. stigmatisation);
4. Economic Harm;
5. Legal Harm; and
6. Harm to the Dignity or dignitary harm or harming a person’s dignity.

**Slide 6**: Balancing Risks and Harms

Risks and benefits may be either *direct* (involving participants) or *indirect* (involving others). They need to be assessed for their *probability* and *magnitude*. They need to be disclosed to participants in the Informed Consent process. Probability of physical risk/harm is often easier to estimate than non-physical harms. Thus, IECs often overestimate or underestimate non-physical risks/harms.

**Minimal Risk**: Defined as: “the probability & magnitude of harm or discomfort anticipated in the research are not greater in and themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests” (Common Rule: 45 CFR 36. 102i).

“Risk” here is being used to loosely to mean some combination of the degree of harm and the probability of experiencing it. In other words, “minimal risk” means that the worst harm that could occur in a study should not be very serious even if many participants experience it and if the harm is serious then the probability of any given participant experiencing it should be quite low.

**Slide 7**: Risk Assessment

Ver may07
Once the risks associated with the research have been identified, the process of categorizing the risks as minimal as or greater than minimal may begin. Two characteristics influence the nature of the risk: the probability of harm and the magnitude of harm. The probability of the harm ranges from rare to likely. The magnitude of harm ranges from mild to severe. Both characteristics vary according to the participant population, the frequency or duration of the intervention(s), and the protections in place to minimize the risk.

<table>
<thead>
<tr>
<th>Probability of Harm</th>
<th>Magnitude of harm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>No harm of any kind</td>
</tr>
</tbody>
</table>

### Slide 8: Vulnerable Groups

Risk and Vulnerability: Because most research involves risk, all research participants are vulnerable to some extent. However, the term vulnerable is used to describe a condition, either intrinsic or situational, of some individuals that puts them at greater risk of being used ethically inappropriate ways in research. In general persons are vulnerable in research either because they have difficulty providing voluntary informed consent arising from limitations in decision making capacity (e.g. children) or situational circumstances (e.g. prisoners) or because they are especially at risk for exploitation (as in the case of persons who belong to “undervalued groups” in society – e.g. lower castes, poor)

### Slides 9 - 11: Addressing Risk in Vulnerable Populations

**Six types of vulnerability and risk minimisation:**

1. 
Risks and Benefits: Analysis and Safety Monitoring

Basic Training on Ethical Issues in Health Research

Module 7

ver may07
Presentation Overview

- Risk/Benefit Analysis
- Ethical Principals underlying Risk/Benefit Analysis
- Defining Potential Harms
- Assessing Risks
- Addressing Risk in Vulnerable Groups
- Benefits
- Framework for Risk/Benefit Analysis
- Monitoring Clinical Trials
Risk/Benefit Analysis

“Every medical research project involving human subjects should be preceded by careful assessment of predictable risks and burdens in comparison with foreseeable benefits to the subject or to others.”

Ethical Principles for Medical Research Involving Human Subjects
WORLD MEDICAL ASSOCIATION DECLARATION OF HELSINKI
Ethical Principles Underlying Risk/Benefit Analysis

- **Nonmaleficence & Beneficence** asserts an obligation to inflict no harm intentionally and requires that positive steps be taken to help others.

- **Justice** requires that risks and benefits be distributed equitably.

- **Confidentiality** requires that researchers take all reasonable measures to safeguard the privacy of participants.
Risks of Participation

- Two components:
  - Probability of harm
  - Magnitude

Thus when one refers to the risks being small, it could mean that the probability of harm is small or the magnitude of the harm is insignificant or both.
Six Types of Harm Research Can Cause

1. Physical Harm
2. Psychological Harm
3. Social Harm
4. Economic Harm
5. Legal Harm
6. Dignitary Harm
Benefits of Participation

- Benefits can accrue to
  - Participants themselves or
  - Others or society in general

- Types of Benefits
  - Direct: need to be taken care of by researchers and examined carefully by ERBs
  - Indirect: may be enhanced in the planning stages if anticipated but need not be included in the evaluation by ERBs
Balancing Risks and Harms

- Risks and benefits may be either *direct* (involving participants) or *indirect* (involving others).

- Risks need to be assessed for their *probability* and *magnitude*.

- Minimal Risks are “not greater in and themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests”.

## Risk Assessment

<table>
<thead>
<tr>
<th>Probability of harm</th>
<th>Magnitude of harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zero</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td>No harm of any kind</td>
<td>Daily hassles</td>
</tr>
<tr>
<td></td>
<td>Strong emotional reaction to survey questions</td>
</tr>
<tr>
<td></td>
<td>Severe social psychological consequences</td>
</tr>
<tr>
<td>Certain</td>
<td></td>
</tr>
</tbody>
</table>
Vulnerable Groups

“Some research populations are vulnerable and need special protection…for those who cannot give or refuse consent for themselves, for those who may be subject to giving consent under duress, for those who will not benefit personally from them research and for those for whom the research is combined with care"

Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects. (Article 8). 1964
Addressing Risk in Vulnerable Populations

Special care is required to minimize:

- **Cognitive or communicative vulnerability**
  - Efforts at facilitating informed choice and overcoming barriers preventing participants to exercise choice

- **Institutional vulnerability**: (e.g. prisoners)
  - Special attention given to participant selection and voluntariness of choice
  - Independence from institution officials and avoidance of incentives
  - Extra emphasis on confidentiality
Addressing Risk in Vulnerable Populations, contd.

- **Differential vulnerability** (under control of others)
  - Ensuring autonomy and free choice – involves cultural and other sensitive negotiations

- **Medical vulnerability** (e.g. seriously ill-patients)
  - Misunderstanding or unreasonable expectations of benefits to be taken care of an independent person not related research and treatment to provide information and facilitate Informed Consent.
Addressing Risks in Vulnerable Populations, contd.

- **Economic vulnerability** (e.g. poor)
  - Avoidance of Incentives and inducements

- **Social vulnerability** (belonging to an undervalued social group including castes, tribes, non-literate, sex workers)
  - Protection against stereotyping and stigmatization
  - Support and empowerment if possible
Benefits

Among the possible benefits of a research study:

- Medical treatment
- Access to new drugs or therapies
- Health education
- Counseling and health referrals
- Scientific knowledge that may benefit the community or society.
- Potential benefits to others – institutional and community capacity building.
Guidance on Balancing Risks/Benefits

- For all biomedical research involving human subjects, the investigator must ensure that potential benefits and risks are reasonably balanced and risks are minimized.

- Risks of such ‘beneficial’ interventions or procedures must be justified in relation to expected benefits to the individual subject

(CIOMS, 2002, Guideline 8)
Guidance on Balancing Risks/Benefits, cont.

- Interventions or procedures that have the prospect of direct diagnostic, therapeutic or preventive benefits for subjects must be as advantageous to study participants as any available alternative.

- Risks of interventions that do not have direct diagnostic, therapeutic or preventive benefits for subjects must be justified by the expected benefits to society. The risks presented by such interventions must be reasonable in relation to the importance of the knowledge to be gained.

(CIOMS-2002 : Guideline 8)
Framework for Risk/Benefit Analysis

In the Components Analysis Method research procedures are classified into those:

- designed solely to answer research questions
- that also offer the prospect of direct benefit to participants

Risks associated with components which:

- answer research questions must be justified primarily by the knowledge gained.
- offer direct benefits to subjects must pass the test of research equipoise (is there sufficient data to show that there is genuine uncertainty?)
Why monitor clinical trials?

- To ensure that the balance between risks and benefits stays favorable to the participants
- To monitor both expected and unforeseen adverse reactions
- To monitor results, particularly if the magnitude of risk is high.
- To determine if a trial should be terminated because uncertainty/equipoise no longer exists.
Data and Safety Monitoring Plan (DSMP)

Data and Safety Monitoring Plans (DSMP) ensure that clinical investigations have a system for appropriate oversight and monitoring. A DSMP has five components:

- Safety Risk Assessment
- Adverse Events Description
- Safety Monitoring Plan
- The Adverse Events (AE) Reporting Plan
- Data Accuracy Plan
Safety Risk Assessment

The Safety Risk Assessment provides information on:

- Magnitude of potential risks categorized into Minimal, Low, Moderate, or High categories.
- Frequency of monitoring—annual, 6 monthly, quarterly, monthly, weekly, day-to-day
The Adverse Events Description includes an explanation of all foreseeable adverse events like side effects, injuries, or complications, which might result in disability, death or require medical treatment, and other threats to participants including loss of confidentiality, etc.
A Safety Monitoring Plan:

- Describes how often data are examined in the course of the research.
- Identifies the parameters at which will be monitored.
- Explains procedures that will ensure adequate feedback of information to researchers and medical decision-makers.
- Describes the oversight or supervisory role of institutional committees.
Adverse Events (AE) Reporting Plan

The Adverse Events (AE) Reporting Plan describes the processes and oversight in place for assuring that AE reporting requirements. It includes a quantitative system to grade the severity of each event:

- 0 = No or within normal limits
- 1 = Mild – did not require treatment or intervention
- 2 = Moderate – resolved with treatment or intervention
- 3 = Severe – resulted in inability to carry on normal activities and required attention of professional
- 4 = Life-threatening or disabling
- 5 = Fatal
A Data Accuracy Plan assures that data is correct and ensures protocol compliance. It:

- describe what quality-control procedures are in place for assuring data accuracy and completeness in studies.
Mechanisms for Data Safety Monitoring

Research can be monitored by:

- researchers.
- sponsors or Institutions.
- a Data and Safety Monitoring Board (DSMB).
- an Institutional Ethics Committee.
Data and Safety Monitoring Board (DSMB)

Data Safety Monitoring Board (DSMB) is a formally appointed independent group consisting assigned to monitor of data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. Membership should include expertise in the relevant field of study, statistics and research design.
References


- National Research Council, Report on “Protecting participants and facilitating social and behavioral sciences research”, USA, 2001 (On your CD: Folder: 02-Reports, Sub-Folder: NRC-Social Behavioral Research)

Module 8: Overview and Functions of Institutional Ethics Committees

By the end of the day the participants should:

- Be familiar with the history, purpose, and makeup of Institutional Ethics Committees (IEC).
- Understand their role and mandate.
- Be able to identify research activities requiring ethical review.
- Understand the procedures and standards IECs use to make decisions

Preparatory Readings:

- ICMR, 2000, Ethical Guidelines for Biomedical Research in Human Participants, ICMR, New Delhi, pp.11-16. Found at: http://icmr.nic.in/ethical.pdf

Training Schedule:

Time: 1 hour 30 minutes (30 minutes for activity and 60 minutes for presentation.) Activities:

- Activity: Presentation of research proposal with a mock IEC review by participants, followed by discussion.

Presentation (60 minutes)

Slide 1: Module Title
Slide 2: Module Objectives
Slide 3: Definition

Institutional Ethical Committees (IEC) are administrative bodies established to protect the rights and welfare of human research participants in research activities of the Indian institution to which the board is affiliated by reviewing proposed research protocols and approving or requesting changes prior to their inception.

In different countries IECs are variously titled:

- In the United States, regulations protecting human participants first became effective the Department of Health, Education and Welfare (DHEW) established the Institutional Review Board (IRB) as one mechanism through which human participants would be protected.

- In the European Union, the term "Ethics Committee" is preferred in the European Union over Institutional Review Boards.

- In some contexts IECs are also referred to as “Independent Ethical Committees”.

Ver may07
Slide 4: Brief history:

The origins of ethics review committees
For most of the 20th century, research involving human participants was not subject to any sort of review process to guarantee that the rights and welfare of the participants would be protected. Some of the more notorious unethical research projects conducted during that time included:

- The Tuskegee Syphilis Study, which ran from 1932 to 1972 and used indigent and poorly educated Black sharecroppers in Alabama to track the natural history of untreated syphilis infections.
- Atrocities committed upon the inmates of Nazi concentration camps during World War II by Dr. Josef Mengele and others under the guise of medical research.
- The Willowbrook Hepatitis Study during the 1950s, in which retarded children institutionalized at the Willowbrook State School in New York were intentionally infected with hepatitis to track the transmission and spread of the disease.
- The testing of ionizing radionuclides on children and young adults without their knowledge or consent by the United States Atomic Energy Commission and Department of Energy during the Cold War.

Public outcry over these and other research projects caused the U.S. Department of Health and Human Services to develop a set of regulations requiring that all proposed clinical research projects at its center in Bethesda obtain approval from a protection of human participants review panel. In 1966, the United States Public Health Service issued its first set of regulations extending this review requirement to all "extramural" research supported by the agency. These rules were further revised in 1971 and 1974 and led to the establishment of institutional review boards (IRBs) at hundreds of research institutions receiving funding from US government.

Mandate for IECs in India

In 2000 the Indian Council of Medical Research issued “Ethical Guidelines for Biomedical Research on Human Participants” that mandated the formation of Institutional Ethics Committees for institutions doing research in India. The guidelines required that “all proposals on biomedical research involving human participants should be cleared by an appropriately constituted Institutional Ethics Committee (IEC), also referred to as Institutional Review Board (IRB) in many countries, to safeguard the welfare and the rights of the participants. The Ethics Committees are entrusted not only with the initial review of the proposed research protocols prior to initiation of the projects but also have a continuing responsibility of regular monitoring for the compliance of the ethics of the approved programmes till the same are completed.”

Slide 5: Responsibilities of IECs

The ICMR has defined the responsibilities of IECs as follows:

- To protect the dignity, rights and well being of the potential research participants.
- To ensure that universal ethical values and international scientific standards are expressed in
terms of local community values and customs

- To assist in the development and the education of a research community responsive to local health care requirements

**Slide 6: Role of IEC**

**IECs are mandated to carry out:**

“An Initial Review” of the research plan before the research is carried out. This review encompasses the research protocol, the informed consent document to be signed by participants, any advertisements to be used in recruiting participants, and other relevant documents. In carrying out this review, the boards seek to ensure that any risks participants may incur are warranted in relation to the anticipated benefits, that informed consent documents clearly convey the risks and the true nature of research, that advertisements are not misleading, and that the selection of participants is equitable and justified. IECs focus much attention on the informed consent document because it is the vehicle for providing information to potential research participants.

A Continuing Review of the research process at an interval appropriate to the degree of risk. In addition to this continuing review, study amendments and reports of unexpected adverse experiences by participants are received periodically and reviewed to ensure that the risk-benefit ratio of the research has not changed and remains acceptable.”

*From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)*

**Slide 7: Makeup of IEC**

**According to the ICMR IECs should:**

*Be multidisciplinary and multisectorial in composition.*

Members should be a mix of medical/non-medical, scientific and non-scientific persons including lay public to reflect differed viewpoints. The suggested composition is:

1. Chairperson
2. 1-2 basic medical scientists.
3. 1-2 clinicians from various Institutes
4. One legal expert or retired judge
5. One social scientist / representative of non-governmental voluntary agency
6. One philosopher / ethicist / theologian
7. One lay person from the community
8. Member Secretary

*Have 5 – 7 members with a max of 12 to 15 to allow for consensus.*

The ICMR guidelines specify that the “number of persons in an ethical committee be kept fairly small (5 – 7 members). It is generally accepted that a minimum of five persons is required to compose a quorum. There is no specific recommendation for a widely acceptable maximum number of persons but it should
be kept in mind that too large a Committee will make it difficult in reaching consensus opinion. 12 to 15 is the maximum recommended number.”

Be chaired by a person from outside the Institution.

According to the ICMR Guidelines: “The Chairperson of the Committee should preferably be from outside the Institution and not head of the same Institution to maintain the independence of the Committee.”

Slide 8: IEC activities

IECs are empowered to:

Make certain that the study has clear objectives and rationale for undertaking research with human participants.

ICMR guidance on this participant states that: “the research entailing the use of human participants is considered to be absolutely essential after a due consideration of all alternatives in the light of the existing knowledge in the proposed area of research and after the proposed research has been duly vetted and considered by an appropriate and responsible body of persons who are external to the particular research and who, after careful consideration, come to the conclusion that the said research is necessary for the advancement of knowledge and for the benefit of all members of the human species and for the ecological and environmental well being of the planet.”

Evaluate and approve all documents, protocols, and inducements related to recruiting participants.

Among the many things the IEC must consider:

- Participant recruitment procedures.
- Inclusion and exclusion criteria for entry of participants in the study.
- Informed protocols with sample of patient information sheet and informed consent forms in English and vernacular languages.
- Proposed compensation and reimbursement of incidental expenses.
- Investigate and approve all treatment plans, drugs, and medical procedures in the study.
- Methodologies of the proposed research, including intended dosages of drugs, planned duration of treatment and details of invasive procedures if any.
- Plans to withdraw or withhold standard therapies in the course of research.
- Safety of proposed intervention and any drug or vaccine to be tested, including results of relevant laboratory and animal research.
- Plans to provide medical therapy for such risk or injury or toxicity due to overdose should be included.

Ver may07
Slide 9: IEC activities, cont.

IEC review must also include:

*Oversight of protocols to ensure the privacy and confidentiality of participants.*

IECs must review:

- Investigator plans for ensuring privacy for participants during examinations or interviews
- Storage and maintenance protocols for all information collected during the trial.
- Plans for statistical analysis of study data.
- Protocols for disclosure of confidential information

*Plans for publication of research findings* These include:

- Proposed methods for publishing the findings of the study, either positive or negative – while maintaining the privacy and confidentiality of participants.

*Documents relating to regulatory compliance.*

Among those required by the ICMR:

- All relevant regulatory clearances.
- An agreement to comply with national and international GCP protocols for clinical trials.

*Details on investigators and funders.*

ICMR requires a review of:

- Recent curriculum vitae of the Investigators indicating qualification and experience.
- Details of Funding agency / Sponsors and fund allocation for the proposed work

Slide 10: Research requiring ethical review

*IEC review of all biomedical research in India is mandated by ICMR*

ICMR: “It is mandatory that all proposals on biomedical research involving human participants should be cleared by an appropriately constituted Institutional Ethics Committee.”

Biomedical research is understood to include:

- Research involving living human participants and use of their medical records.
• Research involving human remains, cadavers, biological fluids, tissues, embryos, fetuses etc.


_Social science research is participant to ethical standards but IEC review is not currently mandated._

The National Committee for Ethics in Social Science Research in health (NCESSRH) has formulated guidelines for ethical review in its report “Ethical Guidelines for Social Science Research in Health” but there are currently no legal mandates for IEC review.

**Slide 11: IEC review process**

“The IEC should be able to provide complete and adequate review of the research proposals submitted to them. It should meet periodically at frequent intervals to review new proposals, evaluate annual progress of ongoing ones and assess final reports of all research activities involving human beings through a previously scheduled agenda, amended wherever appropriate.

The decision must be taken by a broad consensus after the quorum requirements are fulfilled to recommend / reject / suggest modification for a repeat review or advice appropriate steps. The Member Secretary should communicate the decision in writing.”

_From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)_

**Slide 12: Additional requirements for IEC activities**

- A member must voluntarily withdraw from the IEC while making a decision on an application which evokes a conflict of interest, which should be indicated in writing to the chairperson prior to the review and should be, recorded so in the minutes.

- If one of the members has her/his own proposal for review, then the member should not participate when the project is discussed.

- A negative decision should always be supported by clearly defined reasons.

- An IEC may decide to reverse its positive decision on a study in the event of receiving information that may adversely affect the benefit / risk ratio.

- The discontinuation of a trial should be ordered if the IEC finds that the goals of the trial have already been achieved midway or unequivocal results are obtained.

- In case of premature termination of study, notification should include the reasons for termination along with the summary of results conducted till date.

- The following circumstances require the matter to be brought to the attention of IEC:
  - Any amendment to the protocol from the originally approved protocol with proper justification;

Ver may07
- Serious and unexpected adverse events and remedial steps taken to tackle them;
- Any new information that may influence the conduct of the study.

- If necessary, the applicant/investigator may be invited to present the protocol or offer clarifications in the meeting. Representative of the patient groups or interest groups can be invited during deliberations to offer their viewpoint.

- Participant experts may be invited to offer their views, but should not take part in the decision making process. However, her/his opinion must be recorded.

- Minutes must be taken at each meeting and approved and signed by the Chairperson.

From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)

**Slide 13: Specific standards used in IEC deliberations**

IEC deliberations use the following standards which will be reviewed in more detail in the succeeding slides:

- Informed Consent
- Compensation for participation
- Selection of “special groups”
- Confidentiality for prospective research participants
- Compensation for accidental injury
- International research
- Media and publication practices

**Slide 14: Informed consent standard**

Obligations of investigators regarding informed consent:

- Communicate to prospective participants all the information necessary for informed consent.
- Exclude the possibility of unjustified deception, undue influence and intimidation.
- Seek consent only after the prospective participant is adequately informed.
- As a general rule obtain from each prospective participant a signed form as an evidence of informed consent preferably witnessed by a person not related to the trial, and in case of incompetence to do so, a legal guardian or other duly authorized representative.
• Renew the informed consent of each participant, if there are material changes in the conditions or procedures of the research or new information becomes available during the ongoing trial.

• Not use intimidation in any form which invalidates informed consent.

*From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)*

**Slide 15**: Compensation for participation standard

Participants may be paid for the inconvenience and time spent, and should be reimbursed for expenses incurred, in connection with their participation in research. They may also receive free medical services. However, payments should not be so large or the medical services so extensive as to induce prospective participants to consent to participate in research against their better judgment (inducement). All payments, reimbursement and medical services to be provided to research participants should be approved by the IEC. Care should be taken:

• when a guardian is asked to give consent on behalf of an incompetent person, no remuneration should be offered except a refund of out of pocket expenses;

• when a participant is withdrawn from research for medical reasons related to the study the participant should get the benefit for full participation;

• when a participant withdraws for any other reasons he/she should be paid in proportion to the amount of participation.

*From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)*

**Slide 16**: Standard for evaluating “special groups” for research Additional care must be taken in research on the following groups:

**Pregnant or nursing women:**

Pregnant or nursing women should in no circumstances be the participant of any research unless the research carries no more than minimal risk to the fetus or nursing infant and the object of the research is to obtain new knowledge about the fetus, pregnancy and lactation. As a general rule, pregnant or nursing women should not be participants of any clinical trial except such trials as are designed to protect or advance the health of pregnant or nursing women or fetuses or nursing infants, and for which women who are not pregnant or nursing would not be suitable participants.

**Children:**

Before undertaking trial in children the investigator must ensure that –:

• children will not be involved in research that could be carried out equally well with adults;

• the purpose of the research is to obtain knowledge relevant to health needs of children. For
clinical evaluation of a new drug the study in children should always be carried out after the phase III clinical trials in adults. It can be studied earlier only if the drug has a therapeutic value in a primary disease of the children;

- a parent or legal guardian of each child has given proxy consent;
- the assent of the child should be obtained to the extent of the child’s capabilities such as in the case of mature minors, adolescents etc.;
- research should be conducted in settings in which the child and parent can obtain adequate medical and psychological support;
- interventions intended to provide direct diagnostic, therapeutic or preventive benefit for the individual child participant must be justified in relation to anticipated risks involved in the study and anticipated benefits to society;
- the child’s refusal to participate in research must always be respected unless there is no medically acceptable alternative to the therapy provided/ tested, provided the consent has been obtained from parents / guardian;
- interventions that are intended to provide therapeutic benefit are likely to be at least as advantageous to the individual child participant as any available alternative interventions and;
- the risk presented by interventions not intended to benefit the individual child participant is low when compared to the importance of the knowledge that is to be gained.

Vulnerable groups:

- Effort may be made to ensure that individuals or communities invited for research be selected in such a way that the burdens and benefits of the research are equally distributed.
- Research on genetics should not lead to racial inequalities.
- Persons who are economically or socially disadvantaged should not be used to benefit those who are better off than them.
- The rights and welfare of mentally challenged and mentally differently able persons who are incapable of giving informed consent or those with behavioral disorders must be protected.
- Adequate justification is required for the involvement of participants such as prisoners, students, subordinates, employees, service personnel etc. who have reduced autonomy as research participants.

*From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)*

**Slide 17:** Standard of confidentiality for prospective research participants
“The investigator must safeguard the confidentiality of research data, which might lead to the identification of the individual participants. Data of individual participants can be disclosed only in a court of law under the orders of the presiding judge or in some cases may be required to communicate to drug registration authority or to health authority. Therefore, the limitations in maintaining the confidentiality of data should be anticipated and assessed.”

From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)

Slide 18: Compensation for accidental injury

“Research participants who suffer physical injury as a result of their participation are entitled to financial or other assistance to compensate them equitably for any temporary or permanent impairment or disability. In case of death, their dependents are entitled to material compensation. The sponsor whether a pharmaceutical company, a government, or an institution, should agree, before the research begins, to provide compensation for any physical or mental injury for which participants are entitled to compensation or agree to provide insurance coverage for an unforeseen injury whenever possible.”

From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)

Slide 19: Standards for International research

The following special concerns must be addressed in international collaborations:

- Capacity Building:

  Given the magnitude and severity of the health problems in different countries, capacity building to address ethical issues that arise out of collaborative research must be promoted on a priority basis. Strategies should be implemented to build capacity in various countries and communities so that they can practice meaningful self-determination in health development, can ensure the scientific and ethical conduct of research, and can function as equal partners with sponsors and others in a collaborative process. Community representatives should be involved in an early and sustained manner in the design, development, implementation, and distribution of results of research.

- Protection of participants from exploitation

  “Careful consideration should be given to protect the dignity, safety and welfare of the participants when the social contexts of the proposed research can create foreseeable conditions for exploitation of the participants or increase their vulnerability to harm and the steps to be taken to overcome these should be described.

As different kinds of research (epidemiological studies, clinical trials, product development, behavioral and social science oriented research, etc.) have their own particular scientific requirements and specific ethical challenges, the choice of study populations for each type of study should be justified in advance in scientific and ethical terms in all cases, regardless of where the study population is found. Generally, early clinical phases of research, particularly of drugs,
vaccines and devices, should be conducted in communities that are less vulnerable to harm or exploitation. However, for valid scientific and public health reasons, if sufficient scientific and ethical safeguards are ensured it may be considered to conduct research in any phase.”

- **Standard of care**

  “The nature, magnitude, and probability of all foreseeable harms resulting from participation in a collaborative research program should be specified in the research protocol and explained to the participants as fully as can be reasonably done. Moreover, the modalities by which to address these, including provision for the best possible nationally available care to participants who experience adverse reactions to a vaccine or drug under study, compensation for injury related to the research, and referral for psychosocial and legal support if necessary, need to be described.”

- **Burden and the benefit of research**

  “The research protocol should outline the benefits that persons / communities/countries participating in such research should experience as a result of their participation. Care should be taken so that these are not presented in a way that unduly influences freedom of choice in participation. The burden and the benefit should be equally borne by the collaborating countries.”

- **Guidelines, rules, regulations and laws of all participating countries are respected**

  “Guidelines, rules, regulations and laws of all countries participating in collaborative research projects should be respected, especially by researchers in the host country and the sponsor country. These could be with reference to intellectual property rights, exchange of biological materials (human, animal, plant or microbial), data transfer, security issues, and issues of socially or politically sensitive nature. In this context, it is essential for researchers to follow the GOI notification on “Exchange of Human Biological Material for Biomedical Research” issued on 19.11.97.”

*From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)*

**Slide 20: Standards for media and publication practices**

**On accurate reporting of results:**

“Researchers have a responsibility to make sure that the public is accurately informed about results without raising false hopes or expectations. It should also not unnecessarily scare the people. Researchers should take care to avoid talking with journalists or reporters about preliminary findings as seemingly promising research that subsequently cannot be validated could lead to misconceptions if reported prematurely. Or, the results of experimental research may be reported in such a way that it would seem that the human application is round the corner only to be told by the researchers later that considerable time has to pass before these findings can be translated into human use. In such circumstances, retractions most often do not appear in the media. Therefore, it is important to avoid premature reports and publicity stunts.”

**On protection of privacy and confidentiality of participants:**

“Investigator’s publication plans should not threaten the privacy or confidentiality of participants, for
example publication of pedigrees in the report on research in genetics can result in identification of study participants. It is recommended that a clear consent for publication shall be obtained besides the consent for participation in research or treatment and such consent should preferably be obtained on two different occasions and not at the commencement of the study. Maintenance of confidentiality while publishing data should be taken care of. In case there is need for publication / presentation of photographs / slides / videos of participant (s), prior consent to do so should be obtained.”

From: “Ethical Guidelines for Biomedical Research on Human Participants”, Indian Council of Medical Research issued (2000)

Activity : Divide participants into groups of 4 -5 and have them conduct a mock IEC review by participants, followed by discussion. (30 minutes)
Your committee is being asked to review two proposals for research involving human subjects applications. This exercise will provide a platform to consider the ethical issues that arise when evaluating research involving human subjects using any country specific format. Our interest is on protection of potential research participants; please pay particular attention to what the researchers are asking of the subjects. Remember that risks can be physical, psychological social and economic and they can extend beyond the individual actually participating in a project. Your discussions will be most productive if participants have read the applications before the mock IECs meet.

Please note: When reviewing each application, someone from the mock IEC group should record any issues that arise, including questions, if any, that the committee would want answered before making a final decision about approving the study. After full deliberations, the committee votes on an application. There are basically four actions that the committee may take for each application:

- **Outright approval** (at most, only very minor changes are suggested. The application contained all necessary information.)

- **Approval with modifications** (there is enough information to judge the study, but clarification or changes are needed)

- **Resubmit** (there is not enough information to judge the application appropriately, resubmit with required information, attachments etc.)

- **Outright disapproval** (there is no way the researcher can ethically do the study)

This package contains

- IEC Meeting Agenda (1)
- Key considerations in the Review of IEC applications (1)
- Informed consent form checklist (1)
<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Title of Application</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sally Student, MD, MPH Health</td>
<td>Training for Commercial Sex Workers</td>
<td>International</td>
</tr>
<tr>
<td>Steve Scholar, MD International Health</td>
<td>Immune Response to Malaria in an Unexposed Population</td>
<td></td>
</tr>
</tbody>
</table>
Key Considerations in the Review of Ethics Committee Applications

In general, it is difficult to predict where the discussion on a given application will lead until every Institutional Ethics Committee (IEC) member starts to present his/her views (negative and positive). There are several possible outcomes for each application reviewed at a meeting. It is not unusual for the IEC to ask the principal investigator to clarify certain issues, or perhaps require that particular changes be carried out before the ERB would approve the application. Sometimes there is simply too much ambiguity to make a decision on the first round and an application is tabled for future consideration pending extensive revision or clarification. And sometimes an application is approved outright.

The following are some questions to keep in mind as you discuss the proposals:

- Remember that your focus when considering the application should be on protection of potential research participants. Is the proposal clear? Pay particular attention to what the researchers are asking of the subjects.
- Identify the risks to participation in the research (as distinguished from risks the person would face from regular treatment/therapies). Remember that risks can be physical, psychological, social, and economic, and they can extend beyond the individual actually participating in a project. Are the researchers minimizing potential risks? Is there proper disclosure of the risks?
- How do the risks stack up to the potential benefits (first to an individual, then, perhaps, to society in general)?
- How will the researchers maintain confidentiality and privacy? Are there any specific concerns in these areas?
- Is the informed consent form accurate, complete, appropriate? Will the intended audience understand the form? Are the standards for voluntary informed consent being met? Have the researchers ensured that consent will be appropriately obtained and freely given? Note that informed consent is a process, not simply a form.
- How will subjects be selected? Are those who are most likely to benefit from the research the ones being recruited to participate (e.g., those who bear the burden will reap the potential rewards)? Are there any groups that may face particular risks and should therefore be excluded from participation? Could people feel coerced to participate for any reason (e.g., large remuneration offered to poor people, hard for target population to refuse the person recruiting because of some feeling of indebtedness, etc.)?
- Is it ethical to use blood, tissue, or other samples for purposes other than those for which they were specifically gathered? If so, how similar must the new analysis be? If any information is discovered in the specimen analysis that may be beneficial to participants, how should this be handled? Should attempts be made to link the data to the subjects?
<table>
<thead>
<tr>
<th>ESSENTIAL ELEMENTS OF INFORMED CONSENT</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Statement that the study involves research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Explanation of the purpose of the research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expected duration of participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description of the procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identification of <em>research</em> procedures v. <em>non-research</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Description of any reasonably foreseeable risks or discomforts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Description of any benefits to the subject or to others that might be reasonably expected from the research</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Disclosure of appropriate alternative procedures or courses of treatment, if any, that may be advantageous to the subject</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained and what records may be examined by the sponsor, their representatives, and possibly the FDA.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 For research involving more than minimal risk, an explanation as to whether any compensation and medical treatment are available if injury occurs and if, so, what they consist of, or where further information may be obtained. (Standard Format)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Identification of whom to contact for answers to pertinent questions about the research and research subjects' rights, whom to contact if the subject sustains a research-related injury.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Statement that participation is voluntary and that the subject may discontinue at any time. Refusal to participate or withdrawal will not involve a penalty or loss of benefits to which the subject is otherwise entitled.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDITIONAL ELEMENTS ONE OR MORE OF WHICH MAY BE APPROPRIATE</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Any additional costs to the subject that may result from participation in the research.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 The consequences of the subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 A statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue to participate will be provided to the subject.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 The approximate number of subjects involved in the study.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Human Subjects Committee, Harvard School of Public Health, Revised 8/01
Overview and Functions of Institutional Ethics Committees

Basic training on Ethical issues in Health Research

Module 6
Module Objectives

- Explore the history, responsibilities, and makeup of Internal Ethics Committees (IEC).
- Describe IEC responsibilities and activities.
- Identify research requiring ethical review.
- Explore the procedures and standards IECs use to make decisions.
Definition

Institutional Ethics Committees (IEC) are administrative bodies affiliated with institutions that review proposed research in order to protect the rights and welfare of human participants.
Brief History

- The origins of ethics review committees
  - Examples of unethical research prior to human participants protections.
- Mandate for IECs in India
Responsibilities of IECs

- To protect the dignity, rights and well being of potential research participants

- To ensure that universal ethical values and international scientific standards are expressed in terms of local community values and customs

- To assist in the development and the education of a research community responsive to local health care requirements
Role of IEC

IECs are mandated to carry out:

- **An Initial review** prior to the implementation of research that includes the research protocol, informed consent document, advertisements and other relevant documents.

- **Continuing review** that includes evaluation of study amendments and any reports of unexpected adverse experiences by participants.
Makeup of IECs

According to the ICMR IECs should:

- Be multidisciplinary and multisectorial in composition.
- Have 5 – 7 members with a max of 12 to 15 to allow for consensus.
- Be chaired by a person from outside the Institution to maintain the independence of the Committee.
IEC Activities

IECs are empowered to:

- Make certain that the study has clear objectives and rationale for undertaking research with human participants.

- Evaluate and approve all documents, protocols, and inducements related to recruiting participants.

- Investigate and approve all treatment plans, drugs, and procedures in the study.
IEC Activities (contd.)

IEC review must also include:

- Protocols to ensure the privacy and confidentiality of participants
- Plans for publication of research findings
- Documents relating to regulatory compliance
- Details on investigators and funders
Research Requiring Review

- All biomedical research in India is participant to IEC review.

- Social science research is participant to ethical standards but IEC review is not currently mandated.
IEC Review Process

1. Investigator submits application.
2. IEC provides a complete review of the research.
3. Decision is taken by a broad consensus of IEC members to recommend / reject / suggest modification for a repeat review, or advice of appropriate steps.
4. Member Secretary communicates the decision in writing to the Investigator.
Additional Requirements for IECs

- IEC members must voluntarily withdraw from any decision involving conflict of interest.
- The IEC must provide clearly defined reasons for negative decisions.
- A positive decision may be reversed if the IEC receives negative information later.
- A trial can be discontinued if the IEC finds goals have been achieved or unequivocal results obtained.
Specific Standards in IEC Deliberations

- Informed Consent
- Compensation for participation
- Selection of “special groups”
- Confidentiality for prospective research participants
- Compensation for accidental injury
- International research
- Media and publication practices
Informed Consent Standard

“The investigator must obtain the informed consent of the prospective participant or in the case of an individual who is not capable of giving informed consent, the consent of a legal guardian.”
Compensation Standard

“participants may be paid for the inconvenience and time spent, and should be reimbursed for expenses incurred, in connection with their participation in research...Payments should not be so large or the medical services so extensive as to induce prospective participants”
‘Compensation’ standard is contentious in Indian context, particularly in community-based research when the distinctions between research and community development activities may not be clearly made or understood.

Other forms: reimbursement, token of appreciation
Standard for Evaluating “Special Groups”

- Additional care must be taken in research with the following groups:
  - Pregnant or nursing women
  - Children
  - Vulnerable groups
Confidentiality Standard

“The investigator must safeguard the confidentiality of research data, which might lead to the identification of the Individual.”
Compensation for Accidental Injury Standard

“Research participants who suffer physical injury as a result of their participation are entitled to financial or other assistance to compensate them equitably for any temporary or permanent impairment or disability.”
Standards for International Collaborative Research

The following special concerns must be addressed in international collaborations:

- Capacity building
- Protection of participants from exploitation
- Standard of care
- Burdens and benefits of research
- Guidelines, rules, regulations and laws of all participating countries are respected
Standards for Media and Publication Practices

“Researchers have a responsibility to make sure that the public is accurately informed about results...[however] Investigator’s publication plans should not threaten the privacy or confidentiality of participants...”
Thank you
I. Course objectives
At the end of five days of training, the trainees will have learnt about:
1. Substantive and procedural aspects of research ethics.
2. Development of ethics in research, and evolution of ethics guidelines.
3. Ethics principles, their theoretical roots and applications.
4. Ethics review mechanisms and related matters.

II. Salient features of the programme
(a) **Length:** It is between 32 - 40 hrs long, spread over 4 – 5 days.
(b) **Level:** Is appropriate for practicing researchers engaged in public health research.
(c) **Content and Perspective:** It covers the basic aspects of research ethics. In that it covers about 8-10 topics. We have another 8 -10 alternative themes/topics which could replace or combined. Modular form allows flexibility to modify it in tune with the profile and needs of participants.
(d) **Teaching methods:** Uses a blend of didactic and group work using concrete case studies. The latter studies as a major tool for reflections and applications of ethics decision making models and ethics principles. It is complemented by mock ethics review committees.
(e) **Evaluation:** A tool is developed which allows session wise feedback from the participants. The faculty undertakes a mid course review.

III. Faculty

IV. Sessions
The entire training programme consists of 8 modules spread over five days. Each day begins with a summary of the previous day’s proceedings by a volunteer amongst the participants. Participants are encouraged to bring on board additional issues and concerns. Thematic sessions lasting for three hours will involve a combination of a presentation (approximately 1.5 hours) and group discussions (approximately 1.5 hours). Most sessions begin with group discussions on the case studies and are followed by facilitator presentations and discussions.
DAY – 1

0900-0930: Registration

0930-1030: Session I
0900-0915: Welcome
0915-0945: Orientation to the course and ground rules (round of introduction, & ice breakers) etc.
0945-1030: Inauguration and inaugural address

1030-1100: Tea break

1100-1230: Session II
Bioethics Theories and Principles
Presentation and discussion

1230–1330: Lunch break

1330-1500: Session IV:
Power and Hierarchy in Research Settings (not included in this Manual)
Presentation and discussion

1500-1530 Tea Break

1530-1700: Session IV:
Justice and Equity (not included in this Manual)
Presentation and discussion

1700-1800/1900: Film

DAY – 2

0830-0900: Reporting of Day 1, responding to additional issues and concerns

0900-1030: Session V:
Case Studies on Ethical Principle of Informed Consent (Autonomy): Discussion in groups followed by group presentations and discussion

1030-1100: Tea break

1100-1230: Session VI:
Principle of autonomy and Informed consent
Presentation followed by discussion

1230-1330: Lunch break

1330-1500: Session VII:
Case Studies on Privacy and Confidentiality: Discussion in groups followed by group presentations and discussion

1500-1530 Tea break
1530-1700: Session VIII
Privacy and confidentiality
Presentation and Discussion

1700-1800/1900: Film

---

**DAY – 3**

0830-0900: Reporting of Day 2, responding to additional issues and concerns

0900-1030: Session IX:
Case Studies on Ethical Issues in HIV Research: Discussion in groups followed by group presentations and discussion

1030-1100 Tea break

1100-1230: Session X
Ethical Issues in HIV Research
Presentation and Discussion

1230 – 1300 Preparing for mock ethics review *(Amar Jesani and Mala Ramanathan)*

Formation of ethics review groups (mock ethics review committees), distribution of proposal/protocol for review to each group, appointment of lead reviewers for each group and explanation of rules for the mock ethics review on last day

1300-1400 Lunch Time
Mid course break for the participants
Mid course review meeting for the faculty

---

**DAY – 4: May 25, 2006**

0830-0900: Recap of first 3 days, responding to additional issues and concerns

0900-1030: Session XI:
Case Studies on Standards of Care: Discussion in groups followed by group presentations and discussion

1030-1100: Tea Break

1100-1230: Session XII:
Standards of Care
Presentation and Discussion

1230-1330: Lunch break

1330-1500: Session XIII:
Case Studies on Integrity in Research: Discussion in groups followed by group presentations and discussion
1500-1530: Tea break

1530-1700: Session XIV:
Integrity in Research
Presentation and Discussion

1700-1800/1900: Film

DAY – 5 May 26, 2006

0830-0900 Reporting of Day 4, responding to additional issues and concerns

0900-1030: Session XV:
Risks and benefits: analysis and safety monitoring
Presentation and discussion

1030-1100: Tea Break

1100-1230: Session XVI:
Overview and functions of institutional ethics committees
Presentation and Discussion

1230-1530: Session XVII:
Mock Ethics Review of Proposals/Protocols: meetings of ethics committees formed on Day 3
(Lunch and Tea breaks included; Facilitated by Faculty members)

1530-1630: Session XVIII:
Reports by committees and discussion on mock reviews

1630-1730: Session XIX
Valedictory Session
Valedictory Address
Distribution of Certificates
Vote of thanks
Evaluation of the course

Departure
This packet contains separate forms for each day of the training. At the end of each day, there will be time set aside to reflect upon and evaluate the sessions. Your honest feedback and responses will provide valuable information that will help improve the quality and content of this training. When filling out the evaluations, please circle the choice that best represent your evaluation of the course components. Use the blank space for any additional comments. Thank you!
01 Ethical principles and bioethics

Presentation skills: E G F P

Content: E G F P

Responsiveness to questions: E G F P

Comments:

02 Informed Consent

Presentation skills: E G F P

Content: E G F P

Responsiveness to questions: E G F P

Relevance of Case Studies: E G F P

Comments:

03 Privacy and Confidentiality

Presentation skills: E G F P

Content: E G F P

Responsiveness to questions: E G F P

Relevance of Case Studies: E G F P

Comments:
04 Ethical Issues in HIV/AIDS Research

Presentation skills     E G F P
Content                E G F P
Responsiveness to questions  E G F P
Relevance of Case Studies   E G F P
Comments:

05 ‘Standard of Care’ in Health Research

Presentation skills     E G F P
Content                E G F P
Responsiveness to questions  E G F P
Comments:

06 Integrity in Research: Publication, Authorship and Conflict Of Interest

Presentation skills     E G F P
Content                E G F P
Responsiveness to questions  E G F P
Comments:
07 Risk and Benefits

Presentation skills  E G F P

Content  E G F P

Responsiveness to questions  E G F P

Relevance of Case Studies  E G F P

Comments:

08 Overview and Functions of Institutional Ethics Committees

Presentation skills  E G F P

Content  E G F P

Responsiveness to questions  E G F P

Relevance of Case Studies  E G F P

Comments:
**OVERALL COURSE ORGANIZATION**

Please consider the overall course when responding to these questions. Thank you.

1. Overall program rating       E G F P
2. Methods of instruction       E G F P
3. Course materials            E G F P
   (handouts, case studies, articles, etc.)
4. Overall organization of training   E G F P
5. Venue                        E G F P
   Accessibility                  E G F P
   Space                          E G F P
   Food                          E G F P

6. Did this training meet your expectations? If no, why not?

7. What topics and/or speakers should be changed in order to improve the curriculum?

8. Will the information from this course be useful for your work?

9. How can we improve this course?

*Thank you very much for your feedback. Your suggestions and opinions will be very useful as we continue to improve upon our Ethics Training Course!*