Globethics Repository

Current debates on “Standard of Care” in Research on Human Subjects in the Developing World

This page was generated automatically upon download from the Globethics Repository. More information on Globethics see https://www.globethics.net. Data and content policy of Globethics Repository see https://repository.globethics.net/pages/policy.

Item Type	Article
Authors	Rafique, Zoheb
Publisher	Eubios Ethics Institute
Rights	With permission of the license/copyright holder
Download date	2026-06-22 06:43:21
Link to Item	http://hdl.handle.net/20.500.12424/224924

3) Give exposure on brain death to the public through the media and religious bodies. This will help to facilitate doctors to provide information to the patient's family.

Conclusion

Doctors play an important role in the issue of brain death and organ donation. Understanding and good behavior in the issue of brain death is very important. They should be responsible for each task given. Continuing medical education and increasing awareness are keys in increasing the number of brain death diagnosis.

Acknowledgements

We are grateful to the Dr Lam Chee Loong and Dr. Ee Chin Loh (Both are Senior Lecturer and consultant Palliative Medicine) for their cooperation in this study and also to the Medical Ethics Committee, University Malaya Medical Center for the ethics approval (MECID.NO: 20144-158). The study is funded by Postgraduate Research Fund, University of Malaya (PG032-2013B). It was presented at ABC15.

References

Abidin, Zada L Zainal, Wee Tong Ming, Alexander Loch, Ida Hilmi, and Oliver Hautmann, "Are Health Professionals Responsible for the Shortage of Organs from Deceased Donors in Malaysia?," *Transplant international : official journal of the European Society for Organ Transplantation*, 26 (2013), 187–94 <http://dx.doi.org/10.1111/tri.12019>

Afonso, R C, D a B Buttros, D Sakabe, G C Paranhos, L M C Garcia, M B Resende, and others, "Future Doctors and Brain Death: What Is the Prognosis?," *Transplantation proceedings*, 36 (2004), 816–17 <http://dx.doi.org/10.1016/j.transproceed.2004.03.065>

Al-Khader, Abdulla A, "The Iranian Transplant Programme: Comment from an Islamic Perspective.," *Nephrol dial transplant*, 17 (2002), 213–15 <http://www.ncbi.nlm.nih.gov/pubmed/11812868>

Cohen, Jonathan, Sharona Ben Ami, Tamar Ashkenazi, and Pierre Singer, "Attitude of Health Care Professionals to Brain Death: Influence on the Organ Donation Process.," *Clinical transplantation*, 22 (2008), 211–15 <http://dx.doi.org/10.1111/j.1399-0012.2007.00776.x>

Hamdy, Sherine, "Not Quite Dead: Why Egyptian Doctors Refuse the Diagnosis of Death by Neurological Criteria.," *Theoretical medicine and bioethics*, 34 (2013), 147–60 <http://dx.doi.org/10.1007/s11017-013-9245-5>

Harrison AM, and Botkin JR, "Can Pediatricians Define and Apply the Concept of Brain Death?," *Pediatrics*, 103 (1999), 82

Jeon, K.O., B.N. Kim, H.S. Kim, N.-I. Byeon, J.J. Hong, S.H. Bae, and others, "A Study on Knowledge and Attitude toward Brain Death and Organ Retrieval among Health Care Professionals in Korea," *Transplantation Proceedings*, 2012, 859–61 <http://dx.doi.org/10.1016/j.transproceed.2012.02.019>

Kubler, a, M Lipinska-Gediga, J Kedziora, and M Kubler, "Attitudes to Brain Death and Organ Procurement among University Students and Critical Care Physicians in Poland.," *Transplantation proceedings*, 41 (2009), 1473–76 <http://dx.doi.org/10.1016/j.transproceed.2009.01.109>

LS, Hooi, and Lela Yasmin Mansor, *Sixth Report of the National Transplant Registry Malaysia 2009* (Kuala Lumpur, 2011) <http://www.crc.gov.my/pdf/6th NTR report2009.pdf>

Mohamed Ismail Merican, "Guidline Of The Malaysia Medical Council", 2006

Mohd Rani Jusoh, "Mati Otak: Konsensus Pengamal Perubatan," in *Sempadan Bioteknologi Menurut Perspektif Islam*, ed. by Shaikh Mohd Saifuddeen (Kuala Lumpur: Institut Kefahaman Islam Malaysia (IKIM), 2005), pp. 139–52

Schaeffner, Elke S, Wolfram Windisch, Klaus Freidel, Kristin Breitenfeldt, and Wolfgang C Winkelmayer, "Knowledge and Attitude Regarding Organ Donation among Medical Students and Physicians.," *Transplantation*, 77 (2004), 1714–18 <http://dx.doi.org/10.1097/00007890-200406150-00015>

Sheerani, Mughis, Mian Zainul Sajadeen Urfy, Bhojo Khealani, Junaid Patel, Qamarunnisa, and Suresh Rath, "Brain Death: Concepts and Knowledge amongst Health Professionals in Province of Sindh, Pakistan.," *Journal of the Pakistan Medical Association*, 58 (2008), 352–56

Shinzo, Kato, "Organ Transplants and Brain-Dead Donors: A Japanese Doctor's Perspective," *Mortality*, 9 (2004), 13–26 <http://dx.doi.org/10.1080/13576270410001652514>

Sui, W G, Q Yan, S P Xie, H Z Chen, D Li, C X Hu, and others, "Successful Organ Donation from Brain Dead Donors in a Chinese Organ Transplantation Center.," *American journal of transplantation : official journal of the American Society of Transplantation and the American Society of Transplant Surgeons*, 11 (2011), 2247–49 <http://dx.doi.org/10.1111/j.1600-6143.2011.03694.x>

Youngner, S J, C S Landefeld, C J Coulton, B W Juknialis, and M Leary, "'Brain Death' and Organ Retrieval. A Cross-Sectional Survey of Knowledge and Concepts among Health Professionals.," *JAMA : the journal of the American Medical Association*, 261 (1989), 2205–10 <http://dx.doi.org/10.1001/jama.261.15.2205>

Current debates on "Standard of Care" in Research on Human Subjects in the Developing World

- Zoheb Rafique, MBBS, Mbioeth
Lecturer, Department of Biochemistry, Liaquat University of Medical and Health Sciences (LUMHS), Jamshoro, Sindh, Pakistan
Email: dr_zohaib@hotmail.com

Introduction

For sometimes now, medical and bioethics communities have been facing some difficult and divisive issues regarding the ethics of the international research. These issues often get fuel, when the interventional research is conducted on the poor and vulnerable people in the poor developing countries. The common term "Standard of the Care", against which some of new interventions and inventions are tested in the medical research has not been adequately defined. This term is often taken to mean the "best proved treatment" for any of the condition under investigation in any of the trial. The debate regarding what constitutes a reasonable and fair standard of care for subjects in the developing countries, and those who participate in clinical trials has been raised by the critics of the studies on transmission of HIV. Those critics also argued that the placebo controlled trials of the new regimens to prevent the vertical transmission of the HIV were unethical because of the reason that they included the placebo arm rather than "best proven treatment" which is available in the developed countries. While some of the commentators considered criticisms to be unbiased and associated with imperialistic attitudes. Although there was some justified concern that the pressure from US Food and Drug Administration could "dilute" the Declaration of Helsinki, and critics were also confident that whether a trial was ethical could be deduced from text of a declaration. But some

declarations such as Declaration of Helsinki, that governing international research ethics are accepted like the constitutions and needing interpretation. Also assuming what is ethical, goes beyond merely following all the prescriptions and also requires some moral reasoning (1). In this article, I will discuss and comment on various debates on standard of care in human research in the developing world.

Discussion

Equal standards of medical care during research, reflecting equal respect for the dignity of subjects, could be taken to mean any one or a combination of several requirements. It is arbitrary and not justifiable to select only one of these, for example, which drugs are used to compare the standard of care in developed and developing countries. In the context of some disputed studies on the issue of HIV transmission, the forced emphasis on some "best proven drugs" having greater considerations of whether those drug regimens can be safely applied in the different settings. Also little attention has been paid to fact there were so many differences between the pregnant women in the developing countries, and in countries where "best proven" treatment previously been established. The pregnant women in the developing countries present to the antenatal clinics at much later in the pregnancy than women in original studies; they are often malnourished and anemic, and they often live within some context in which breast feeding has different implications for the newborn infants. Moreover, the advice don't breast feed would then contradict years of the intensive education by WHO (World Health Organization). Also concerning the use of the placebos, the approach has also been simplistic. A placebo arm is legal and justified in any trial requires some careful consideration of the potential benefits and harms in those specific contexts and they cannot be just simply deduced from any general declaration. Of course it is very necessary to acknowledge the fact that many of the placebo trials are often unethical because they are performed largely for the marketing purposes just to show that "me too" drugs, have effects and actions greater than those placebo, and rather than to study that they are better than the existing similar, often cheaper, drugs. Also not only should nothing be done to make it easier to perform such trials, but also each and every effort can be made to reduce and decrease wasting time, and money on the "promotional studies". In these situations where there are some good reasons for the placebo controlled trials, those should be considered on the merits rather than to be precluded by any bluntly designed clause in the declaration. To protect the host communities from exploitation, most of the commentators argue that the efforts to improve the health care in developing countries should never ever involve research that uses and utilizes less than "Worldwide best" methods, and meaning best of methods available anywhere in the world. Most notably, paragraph 29 of the Declaration of Helsinki states: "*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 debate over the issue what standard of care should be required for the individuals participating in the research trials typically focuses on research conducted in the developing countries by the investigators from the developed countries. This focus makes some sense. Most clinical research is conducted by investigators from developed countries, and most communities lacking access to good health care are located in developing countries. Researchers from the developing countries can also exploit the host communities. Also the communities in developed countries lack access to the best methods available in the world, and increasing the potential of being exploited. Then a complete analysis, should also address the potential for exploitation and independent of nationality of investigators, and the geographic location of any study (2). When the Helsinki Declaration calls for *"the best proven therapeutic method"* than does it mean [A] "*the best therapy which is available anywhere in world"?* Or does it say [B] *"the standard that is applicable in that country in which drug trial is conducted"?* Helsinki is not very clear about this. But I must say that [1] a detailed and careful analysis of document and also its history tells us that the best therapy standard was intended initially and primarily as the standard of medial practice. This conclusion yields another conclusion: that [2] "*the best proven standard of therapy must necessarily be the standard which prevails in that country in which clinical trial is being carried out."* In part, interpretations A and B often differ over what we can call the question of relevant reference point. Also emphasizing this disagreement makes it appear as the dispute hinges on question of whose medical practice constitutes relevant medical practice. So, the sides of the debate are divided into the proponents of local standard of care and also the critics who often champion the global standard of care. Framing the debate as the question of relevant reference point, however, effectively obscures a more fundamental source of disagreement. To see this, consider a crucial assumption that lies behind following argument. It is sometimes claimed that (1) because content of the standard of care is often fixed by local reference point and (2) because the prevailing treatment for preventing the maternal-infant HIV transmission in those countries where short-course AZT trials were conducted was no treatment at all, that (3) use of the placebo does not fall below established standard of care. Also it is important to see, however, that in order for (3) to follow from (1) and (2), we have to adopt the local reference point for standard of care (3). The ethics of the placebo-controlled trials to prevent the perinatal transmission of the HIV infection in continents like Asia and Africa have been widely debated. Some critics have argued that it is very unethical to leave the patients untreated when the proven life-saving treatment and therapy is being used in other parts of the world. We note, that conduct of the placebo-controlled trials in any developed country which would be unethical in some other developed country, has evoked some of furor that surrounded HIV perinatal transmission trials. The patients on other hand can choose not to take part in the trials. Reluctance to participate in the trial may be greater when there is some placebo control and the patients are asked to delay and forgo known effective therapy, also a large number of the patients regularly agree to take part in the placebo-controlled trials of new agents. The perceived scientific value of the trial can contribute to this decision. Although care must be taken to ensure that manipulation of such considerations (e.g., by exaggerating scientific importance of trial), it seems very reasonable to allow the potential study participants to balance these benefits against some potential risk of the participation in this trial (4). Some of the observers noted more than decade ago that the research was conducted in the developing countries without the concern for the adherence of international ethical principles regarding human subject research contained in 1947 Nuremberg code and also in the 1964 Declaration of Helsinki. This situation has not improved. For example, two years back, the Food and Drug Administration decided that the research studies submitted to it for the review purpose need no longer be bound by the Declaration of Helsinki and they must follow only the industry-sponsored guidelines for the good clinical practice also outlined by International conference on the Harmonization. What is the legal status of Nuremberg code and Declaration of Helsinki? Are they old outdated ethical rules that the researchers might ignore with impunity? The question remains open, but just as clinical trials attempting to interrupt

mother-to-child transmission of HIV in mid-1990s gave rise to some continuing debate about the global standards of care and also benefit sharing, so another mid-1990s research trial in continental Africa has brought the international research rules back to the center stage (5). In addition to discussing recent debate and concerning international HIV research, also we should focus on whether or not to randomize, as the controlled trials must be conducted for the researchers to learn about intervention's efficacy. The choice of the study design is not between ethically questionable perfect trials that produce the complete knowledge versus the imperfect designs that produce no knowledge. Moreover designs, such as the observational studies, that resolve the certain ethical quandaries are not necessarily free of the other ethical problems. One problem is that these studies can provide only limited guidance for the public health policy. The other issue is of informed consent, which is one of the corner-stones of research ethics. The quality of the informed consent is compromised when the potential patient participants believe, wrongly, that the medical care is contingent on their agreeing to participate in the research. Also it is important to emphasize the potential participants that neither their access to the medical care, nor quality of care they receive, will be affected in any of the respect by their decision. It is sometimes very difficult to clarify this separation of the research from the medical care; the potential participants can be made aware through the effective communication that the decision about the research has no implications for their medical interests. Some more challenging situation occurs when the potential participants rightly believe that the medical care is contingent on their agreeing to enroll in the research (6).

Conclusion

In conclusion it is stated that 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 subjects or to others. Following the fundamental principles of bioethics may help to reduce ethical issues while conducting the clinical trials in resource poor countries. The issues of doing research in the developing countries remains a worry and it need to be focused and debated. We have to sort out ethical problems while conducting any research study. The researchers following the ethical rules might not been able to solve all issues, but the situation might improve by the time if we try it sincerely.

References

1. Solomon R Benatar, Peter A Singer. A new look at international research ethics. *BMJ* 2000; Vol. 321, 824-826.

2. David Wendler Et Al. The Standard of Care Debate: Can Research in Developing Countries Be Both Ethical and Responsive to Those Countries' Health Needs? *AJPH* 2004; Vol. 94, No. 6, 923-928.

3. Alex John London. The Ambiguity and the Exigency: Clarifying 'Standard of Care' Arguments in International Research. Journ*al of Medicine and Philosophy* 2000; Vol. 25, No. 4, 379-397.

4. Susan S. Ellenberg, and Robert Temple. Placebo-Controlled Trials and Active-Control Trials in the Evaluation of New Treatments. *Annals of Internal Medicine* 2000; Vol. 133, No. 6, 464-470.

5. George J. Annas, J.D. Globalized Clinical Trials and Informed Consent. *NEJM* 2009; 360; 20, 2050-2053.

6. Ruth Faden, Nancy Kass. Editorial: HIV Research, Ethics, and the Developing World. *AJPH* 1998; Vol. 88, No. 4, 548- 550.

Deficiencies in Japan's Medical Ethics Review System

- Akio Kanayama
Tokyo Metropolitan Kitatama College of Nursing
Part-time Lecturer, Tokyo Metropolitan Kitatama Nursing Colleges
Bureau of Social Welfare and Public of Health, Tokyo Metropolitan Govemment, Japan
Email: m10702055@gmail.com

Abstract

A major factor in many cases of medical malpractice is the failure of doctor–patient communication. Independent third-party organizations such as the HEC (Hospital Ethics Committees) and the Clinical Ethics Consultation (CEC) are designed to address this problem in the United States and Canada. However, in Japan, open public access to similar patient advocacy groups is less widespread. This deficiency may be contributing to instances of illicit medical practices in Japan and posing as a significant impediment to the realization of "patient-centered health care." Illicit activities such as casually tampering with medical records in order to conceal incidents of medical malpractice occur frequently in Japan, as illustrated by several cases discussed in this paper. The fact that investigations are conducted only after a serious incident occurs reflects the inadequacy of existing ethical safeguards.

Key words: medical malpractice, hospital ethics committee, clinical ethics consultation, informed consent, neutral institution.

Introduction

Actions involving communication between medical professionals and patients, including informed consent (IC), are a frequent cause of problems between medical professionals and patients in modern healthcare. These problems arise from the increasing complexity of healthcare decision-making amidst rapid advancements in medical technologies, a wider range of treatment options, and transformations in social structures. Therefore, the availability of neutral third parties to investigate whether sufficient ethical consideration has occurred in decisions on treatment plans is an important issue. This paper highlights the current status of third-party ethics committees in Japan, where illicit activities such as tampering with medical records continue to occur with surprising frequency.

The current state and issues of ethics committees and clinical ethics consultations in Japan

Since the 2003 amendment to the Enforcement Regulations of the Medical Service Law, which governs hospitals and research facilities in Japan, advanced treatment hospitals and clinical training hospitals have been required to "provide patient consultation services." This provision has led to the establishment of patient consultation desks at all university hospitals and all so-called "large" hospitals (i.e., those with at least 400 beds). Ethics committees (ECs) began reviewing cases from clinical settings, and hospital ethics committees (HECs) [30] designed to address ethical issues in clinical practice were also formed. HECs in the western countries are composed of physicians, nurses, medical social workers,

[30]Chris Hackler and D. Micah Hester, "What Should an HEC Look and Act Like?" in D. Micah Hester (ed.), *Ethics by Committee: A Textbook on Consultation, Organization, and Education for Hospital Ethics Committees* (Maryland, Rowman & Littlefield, 2007), 6–12.