Structural Violence in Global Clinical Research

Julia Sese
FCRH Class of 2020- Biological Sciences
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Professors Matthew Weinshenker & Steven Swartzer
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For the first half of my education at Fordham, I was determined to become a doctor and practice medicine abroad in countries that do not have access to adequate health care. It was not until my Junior year, after taking “Anthropology of Health and Healing,” that I realized how naive my trust in Western medical research was to be the panacea for all global healthcare inequalities. Growing up with a mom as an emergency room nurse and a dad as a physicians assistant, I never questioned the benevolence of healthcare workers or considered how biomedical researchers could enact harm to vulnerable populations. I always thought, “Our medicine is supposed to help those people. How could clinical researchers and their administered treatments be more harmful than not acting at all?”.

Within the first two weeks of “Anthropology of Health and Healing,” my worldview was completely shifted. I never understood the longevity of Western colonial influence on global medical conventions, from sexist language in biological concepts to overall industrial ideals about human health, such as the metaphorical comparison of the body as machine and organs as replaceable parts. We also read about the healing practices of different native cultures across the world and how some developed skeptical attitudes toward Western medicines and the foreign practitioners who imposed new vaccines, treatments, and programs to allegedly help their communities. Our professor often highlighted the history of cultural imperialism and exploitation by western missionaries and researchers under the guise of introducing these communities to “science” and better healthcare practices.

The class cast a light on the structural violence that occurs during research abroad. Structural violence is a term used to describe the cultural, economic, political, and religious hierarchies or power structures that create inequalities that physically harm people or prevent certain groups from meeting their basic human needs (Farmer, 2006). Developing countries are easily exposed to structural violence, especially at the hands of doctors and researchers who gain access to vulnerable communities to conduct clinical research.

Filled with jumbled thoughts, broken ideals, and a newly critical outlook on Western medical interventions in developing nations, I left "Anthropology of Health and Healing" with more questions than I started with. What is the role of a healthcare professional who also conducts clinical research? How do they balance research and care? Who benefits more from these interactions: the researchers, the companies who fund these studies, or the participants? What are participants entitled to and how are they properly informed? How are power imbalances counteracted between researchers and participants? Most importantly, is research that is meant to better global public health and knowledge being performed at the expense of harming marginalized groups?

To attempt to answer these questions, researchers look to The Belmont Report for guidance. The Belmont Report was created in 1979 to develop an ethical standard and specific federal regulations for all research involving human subjects. Overall, the text highlights the importance of three principles: respect for persons, beneficence, and justice (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). Respect for persons involves equipping research participants with the information and autonomy to make freely decide to contribute to the study. In clinical trials this is embodied in informed consent, in which researchers ensure that subjects are clearly informed about the study, comprehend it, and are not under undue influence to participate. Beneficence includes the basic principle to do no harm, maximizing benefits while minimizing harm. In clinical research, this can be seen in the researcher's required assessment of risk and benefit ratios to determine which party, participant or greater society, benefits more. The assessment also evaluates the study's utility as a whole. Lastly, justice safeguards fairness in research. The Belmont Report specifically highlights the fair selection of subjects, such as selecting individuals from privileged groups before vulnerable populations. In global research this is especially important to ensure that groups are selected for studies that are feasible within the community and are most likely to produce improvements to existing local health-care systems, without post-research damage after research.

In order to fulfill the requirements of the Belmont Report, several precautions are needed to conduct clinical research in developing countries. It is crucial that participants are provided an appropriate standard of care, sustainable interventions, and clear informed consent. Based on The Belmont Report, I found that there are numerous ethical requirements for international clinical research. A collaborative partnership, social value, scientific validity, fair selection of study population, favorable risk-benefit ratio, independent review, informed consent, and respect for participants and their communities are just a few broad principles that should be met by researchers (Emanuel et al., 2004). What distinguishes global clinical research from local and national research is the need to collaborate with those from different cultures and backgrounds to ensure that their values are respected. One way researchers can accomplish this is through complete transparency and equal partnerships with communities and their leaders. Specifically, researchers should: identify the risk-benefit ratio for all involved, clearly explain the benefits and risks to participants in a culturally appropriate way, involve the community in recruitment methods and incentives, ensure accountability and formulate interventions that ensure the best possible health outcomes, disclose their right to withdraw from the study, and to eventually disseminate all information from the study to the communities involved (Emanuel et al., 2004). These benchmarks all ultimately ensure that the autonomy of participants is respected. This is crucial in disadvantaged communities that are susceptible to the dangerous, neocolonial research practices that are used to control black and brown bodies. Global participants should feel in control of their health and partnership with researchers in order for the clinical research to be ethical.

Finishing up my senior year, I have taken off the rose-colored glasses and can see healthcare research for what it is: an insidiously flawed field that requires constant amendments and protections for both researchers and participants. I used to want to be a doctor. Now I don't. In developing my morals and personal beliefs, I discovered that I could make a difference in the health of marginalized communities, not by being a doctor, but as a public health professional. In a career in public health I would be able to not only be able to work with patients and research participants individually, but also work with different community leaders and policy makers to better the overall systems that impact disenfranchised groups. While the Belmont Report represents a standard of care for human research, it is important to evaluate research situationally and with a critical lens that accounts for structural violence. Eventually, as a public health researcher, I hope to help combat structural violence and empower underserved communities to make autonomous decisions about their healthcare.

Works Cited

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