Recently proposed changes to legal and ethical guidelines governing human subjects research

Emily A. Largent*

Petrie-Flom Center, Program in Health Policy, Harvard Law School, 23 Everett Street, Cambridge, MA 02138, USA
*Corresponding author. E-mail: elargent@jd16.law.harvard.edu

In recent months, updates have been proposed to two important documents in human subjects research oversight: the Federal Policy for the Protection of Human Subjects or ‘Common Rule’1 and the Council for International Organizations of Medical Sciences (CIOMS) Ethical Guidelines for Biomedical Research2 (hereafter, ‘CIOMS Guidelines’). The two proposals have garnered significant attention within the research community because, if finalized, they would be the first major revisions to these documents since 1991 and 2002, respectively. Moreover, they include substantive changes that could have far-reaching effects on the conduct of human subjects research.

Human subjects research—research in which human beings are the subjects of study—is governed by ‘a series of international codes, national legislation, and agency regulations. The regulatory framework has evolved over time, often shifting in the aftermath of tragedy3 and scandal.4 Consequently, there is a tendency to emphasize some ethical requirements while overlooking others.5 Additionally, research itself is evolving, and guidelines may offer incomplete guidance (or no guidance), for example, in

1 See HHS. GOV, Federal Policy for the Protection of Human Subjects, http://www.hhs.gov/ohrp/humansubjects/commonrule/ (accessed Jan. 6, 2016).
2 Council for International Organizations of Medical Sciences (CIOMS), International Ethical Guidelines for Biomedical Research Involving Human Subjects (2002), http://www.cioms.ch/publications/layout_guide2002.pdf (Book).
3 Erin D. Williams, Congressional Research Service, Federal Protection for Human Research Subjects: An Analysis of the Common Rule and Its Interactions with FDA Regulations and the HIPAA Privacy Rule, CRS-12 (2005).
4 Ezekiel J. Emanuel, David Wendler & Christine Grady, What Makes Clinical Research Ethical?, 283 JAMA 2701, 2701 (2000).
5 Id. at 2701, 2702.
Recently proposed changes to legal and ethical guidelines governing human subjects research

...the face of advances in medicine or new methods of conducting research. As a result, the regulatory framework must continually evolve. Even understanding this, one might reasonably ask: Why are changes being proposed now?

Over the last several decades, the volume and nature of human subjects research have changed considerably. Human subjects research has grown in scale while becoming more diverse. Today, studies are more likely to enroll large numbers of research participants and to span multiple sites. Research participants are more likely to be collaborative partners in research, rather than simply the objects of study.

Other developments include:

- An expansion in the number and type of clinical trials, as well as observational studies and cohort studies; a diversification of the types of social and behavioral research being used in human subjects research; increased use of sophisticated analytic techniques for use with human biospecimens; and the growing use of electronic health data and other digital records to enable very large data sets to be analyzed and combined in novel ways.

These changes have been accompanied by considerable debate about the ethics of human subjects research. Proposed revisions to both the Common Rule and the CIOMS Guidelines emerged from this rich context of substantive change and normative debate.

Although the Common Rule and the CIOMS Guidelines both pertain to the conduct of human subjects research, they are qualitatively different. The Common Rule contains the US federal regulations governing most research with human subjects funded or conducted by the government. In contrast, the CIOMS Guidelines were written for application ‘particularly in developing countries’ and are not legally binding. They have, however, been codified in or influenced national laws and regulations. Appreciation of these differences is essential to understanding why the proposed changes were drafted the way they were, the practical effects these proposed changes might have on human subjects research, and the relative urgency with which the research community is critiquing them.

This Development will proceed as follows. Part I will examine the Notice of Proposed Rulemaking (NPRM) that proposes changes to the Common Rule. Part II will highlight proposed changes to the CIOMS Guidelines. Part III concludes. While some

---

6 Leslie Meltzer Henry, Revising the Common Rule: Prospects and Challenges, 41 J. L. MED. & ETHICS 386, 386 (2013).
7 Kathy L. Hudson & Francis S. Collins, Bringing the Common Rule into the 21st Century, 373 NEJM 2293, 2293 (2015).
8 Id.; see generally Pcori, Patient-Centered Outcomes Research, http://www.pcori.org/research-results/patient-centered-outcomes-research (accessed Jan. 4, 2016).
9 Notice of Proposed Rule Making, Federal Policy for the Protection of Human Subjects, 80 Fed. Reg. 53,933, 53,935 (to be codified at 45 C.F.R. pt. 46) (proposed Sept. 8, 2015); see also id. at 53,938.
10 James V. Lavery, Putting International Research Ethics Guidelines to Work for the Benefit of Developing Countries, 4 YALE J. HEALTH POL’Y L. & ETHICS 319, 324 (2004).
11 CIOMS, supra note 2, at 7.
of these changes are controversial and involve compromise, I suggest that they are, on the whole, positive and should be welcomed as an advance over the status quo.

I. NOTICE OF PROPOSED RULEMAKING

Federal laws governing human subjects research demonstrate ‘a societal commitment to the advancement of scientific knowledge provided that the advances occur in accord with ethically sound principles and practices’. The Common Rule, now codified in separate regulations by 18 Federal departments and agencies, is ‘a uniform regulatory floor for human subjects research... which generally requires informed consent, independent ethical review, and the minimization of avoidable risks’.  

Within the US context, there has been documentation of problems with the extant regulations and their application. For instance:

Informed-consent documents grow ever longer and consistently exceed the eighth-grade reading level, with wide variation in participants’ comprehension. Researchers have documented unjustified variation in assessments of studies’ risks and benefits. And the review system is inefficient, with numerous [institutional review board (IRB)] reviews for multicenter studies delaying initiation of research for months or years, despite little evidence that multiple reviews enhance protections.  

Many, therefore, feel that changes are needed to enhance protections for research participants, improve efficiency, and reflect the changing nature of research.

In November 2009, representatives from the Department of Health and Human Services (HHS) and other departments convened to reform the Common Rule with the dual aims of enhancing research participant protections and increasing the efficiency of the research oversight process. Those meetings led to the release of an Advanced Notice of Proposed Rulemaking (ANPRM) in July 2011. In September 2015, the long awaited NPRM was published in the Federal Register. The NPRM was initially open for public comment through December 7, 2015; however, the comment period was subsequently extended until January 6, 2016, after widespread demands for additional time to consider and comment on the complex proposals. With the comment period now closed, it is up to regulators to determine whether to proceed with the final

---

12 Jonathan Moreno, Arthur L. Caplan & Paul Root Wolpe, , Updating Protections for Human Subjects Involved in Research. Project on Informed Consent, Human Research Ethics Group 280 JAMA 1951, 1951 (1998).
13 PRESIDENTIAL COMMISSION FOR THE STUDY OF BIOETHICAL ISSUES (PCSBI), MORAL SCIENCE: PROTECTING PARTICIPANTS IN HUMAN SUBJECTS RESEARCH 2 (2011). All participating departments and agencies include language identical to that of the Department of Health and Human Services (HHS) codification at 45 C.F.R 46, subpart A in their chapters of the Code of Federal Regulations.
14 Ezekiel J. Emanuel, Reform of Clinical Research Regulations, Finally, 373 NEJM 2296, 2297 (2015).
15 Id. at 2297.
16 HHS, Human Subjects Research Protections: Enhancing Protections for Research Subjects and Reducing Burden, Delay, and Ambiguity for Investigators, 76 FED. REG. 44,512 (2011).
17 Leslie M. Henry, Revising the Common Rule: Prospects and Challenges, 41 J. L. MED. & ETHICS 386, 387 (2013) (describing ‘pessimism’ that progress toward issuing a NPRM was ‘stalled, at least for the foreseeable future, if not permanently’).
18 HHS, supra note 17, at 53,933.
19 The NPRM includes more than 80 questions for public comment. Various groups, including the Secretary’s Advisory Committee on Human Research Protections (SACHRP) recommended an extension of the public comment period. SACHRP, November 3, 2015 Letter to the HHS Secretary,
Recently proposed changes to legal and ethical guidelines governing human subjects research

rule.\textsuperscript{21} The timeline is unclear, and there is no legal requirement for a final rule at all, but many have advocated moving forward as quickly as possible.\textsuperscript{22}

Coming in at 131 Federal Register pages, the NPRM proposes several significant changes to the Common Rule aimed at: improving the informed consent process; strengthening consent requirements for use of stored biospecimens in research; limiting use of waivers and alteration of consent for research involving biospecimens; excluding certain kinds of activities from coverage under the Common Rule; adding additional categories of exempt research; mandating that US institutions engaged in cooperative research rely on a single IRB; eliminating continuing review for studies that undergo expedited review and for studies that have completed study interventions; and extending the scope of the policy to cover all clinical trials conducted at US institutions that receive federal funding for human subjects research.\textsuperscript{23}

The NPRM was highly anticipated and, therefore, subject to great scrutiny upon publication. There has been a flood of commentary from researchers, individuals involved in research oversight, and research ethicists. Here, I will focus on three prominent changes: consent for research use of biospecimens; review of cooperative research by a single IRB; and informed consent documents.

I.1. Use of Stored Biospecimens

Biospecimens are materials taken from the human body—for instance, blood, tissue, saliva, and urine—that can be used for either clinical or research purposes.\textsuperscript{24} ‘Billions’ of biospecimens are now in storage.\textsuperscript{25} Because biospecimens contain a tremendous amount of biological information, they can be used by researchers to identify ‘the role that genes play in disease formation... develop new diagnostic tests and targeted treatments for specific diseases and to investigate how genes interact with environmental factors’.\textsuperscript{26} They may also lay the necessary foundation for ‘personalized medicine’, treatments customized to an individual’s genetic profile.\textsuperscript{27}

At present, the Common Rule applies to the secondary research use of biospecimens (meaning use of specimens originally collected for another purpose, either clinical care
Recently proposed changes to legal and ethical guidelines governing human subjects research

or other research) only if the biospecimens are identifiable. In practice, that means that secondary research on biospecimens can generally be done without IRB review or consent if the biospecimens are not identifiable. If adopted, the NPRM would expand the Common Rule’s definition of ‘human subject’ to include a ‘living individual about whom an investigator... (iii) obtains, uses, studies, or analyses biospecimens’ and to cover ‘all’ research use of biospecimens, regardless of whether the biospecimens are or are not identifiable.

In almost all circumstances, the NPRM would require informed consent for use of stored biospecimens in secondary research. That consent would generally be obtained by means of ‘broad’ consent, a template for which would be provided by the regulators if the rule is finalized. Broad consent has been defined as ‘consent for an unspecified range of future research subject to a few content and/or process restrictions. Broad consent is less specific than consent for each use, but more narrow than open-ended permission without any limitations (ie. ‘blanket’ consent)’. The intent of broad consent is to show respect for individuals by allowing them to decide whether they want their biospecimens and data used for research while obviating the need for consent to each subsequent research project.

These proposals are, in part, a response to criticisms that the Common Rule cannot account for recent advances in science that pose novel risks for privacy and confidentiality. The preamble to the NPRM explains that with already existing tools and technologies, ‘biospecimens can be used to generate information unique to individuals and therefore cannot be truly deidentified’. The NPRM also points to the autonomy interests of biospecimen sources.

It is widely accepted that requiring consent for the use of biospecimens in secondary research will create challenges for the research community. These include additional administrative burdens to implement a broad consent process and to track the consent status of individual biospecimens. In response to comments received regarding the ANPRM, the NPRM proposes that the new definition of ‘human subject’ would apply prospectively, and compliance with the provision would be delayed until three years after publication of a final rule.

I.2. Review of Cooperative Research by a Single IRB

An IRB is an administrative body with the authority to approve, require modifications in, or disapprove human subjects research activities conducted under the auspices of

---

28 ‘Human subject’ is currently defined as ‘a living individual about whom an investigator… conducting research obtains (1) data through intervention or interaction with the individual or (2) identifiable private information’. 45 C.F.R § 46,102(f) (2005).
29 Id. § 46,102(e)(1).
30 Ropes & Gray, HHS Proposes Major Overhaul of the Common Rule (Sept. 8, 2015).
31 HHS, supra note 9, at 53,937.
32 Grady, Eckstein & Berkman et al., supra note 25, at 35.
33 Brett A. Williams & Leslie E. Wolf, Biobanking, Consent, and Certificates of Confidentiality: Does the ANPRM Muddy the Water?, 41 J. L. MED. & ETHICS 440, 440 (2013).
34 Hudson & Collins, supra note 7, at 2294.
35 HHS, supra note 17, at 53,938.
36 Hudson & Collins, supra note 7, at 2294.
37 HHS, supra note 17, at 53,943.
Recently proposed changes to legal and ethical guidelines governing human subjects research

the institution with which it is affiliated.\textsuperscript{38} Currently, many studies are carried out at multiple sites.\textsuperscript{39} This can help with recruitment of a larger number of research participants and more diverse study populations. At present, IRB approval is typically required at each study site. A criticism of the current redundant review process is that it can create inefficiencies and add delays without increasing the protections enjoyed by research participants.\textsuperscript{40}

The NPRM would therefore require participating US institutions engaged in cooperative research to rely on a single IRB.\textsuperscript{41} This proposal is consistent with a draft policy issued by the National Institutes of Health (NIH) to promote the use of single IRBs in multi-site clinical research studies.\textsuperscript{42} The draft NIH policy would expect all NIH-funded multi-site studies carried out in the United States to use a single IRB.\textsuperscript{43} The response to NIH’s proposed policy is characterized in the NPRM as ‘robust and largely supportive’.\textsuperscript{44}

One concern of those opposed to mandatory use of a single IRB is the potential for loss of accountability and ‘increased liability for the institutions where research is conducted but where the reviewing IRB is not located’.\textsuperscript{45} To protect against this concern, the NPRM proposes to ‘give Common Rule departments and agencies the authority to enforce compliance directly against unaffiliated IRBs that are not operated by an assured institution’.\textsuperscript{46} Others are concerned that the proposal may not actually enhance efficiency if there is a need for robust agreements to establish the authority of the central and participating IRBs, to define respective responsibilities and to structure the means for interinstitution information-sharing.\textsuperscript{47} Moreover, it may be difficult for investigators to learn the system of multiple IRBs, rather than just their own institution’s system, and special issues presented by local populations may be overlooked.\textsuperscript{48}

I.3. Informed Consent Documents

As mentioned above, there are long-standing complaints about informed consent documents, ‘namely, that they are too long, too complicated, and filled with legal text

\textsuperscript{38} HHS, IRB Guidebook (1993), http://www.hhs.gov/ohrp/archive/irb/irb_chapter1.htm
\textsuperscript{39} Hudson & Collins, supra note 7, at 2295.
\textsuperscript{40} See eg Petra Kaufmann & P. Pearl O’Rourke, Central Institutional Review Board Review for an Academic Trial Network, 90 Acad. Med. 321 (2015).
\textsuperscript{41} § 114(b)(1). The requirement that all institutions engaged in cooperative research rely on a single IRB would not apply to either cooperative research for which more than single IRB review is required by law, or research for which it is deemed not appropriate for the particular study. § 114(b)(2).
\textsuperscript{42} National Institutes of Health (NIH), Request for Comments on Draft NIH Policy on the Use of a Single Institutional Review Board for Multi-Site Research, https://grants.nih.gov/grants/guide/notice-files/NOT-OD-15-026.html (accessed Jan. 4, 2016).
\textsuperscript{43} Id. (allowing exceptions if local IRB review is necessary to meet the needs of specific populations or where required by federal, tribal, or state laws or regulations).
\textsuperscript{44} HHS, supra note 9, at 53,983.
\textsuperscript{45} Id.
\textsuperscript{46} § 101(a).
\textsuperscript{47} Eg Elisa A. Hurley, PRIM&R, Unpacking the NPRM: Single IRB Review and Continuing Review, http://blog.primr.org/nprm-single-irb-review/ (accessed Jan. 5, 2016).
\textsuperscript{48} SACHRP, Recommendations on the Notice of Proposed Rulemaking entitled “Federal Policy for the Protection of Human Subjects,” http://www.hhs.gov/ohrp/sachrp/commsec/attachmenta:recommendationsnprmletter1/5/16.html (accessed Jan 25, 2016).
Recently proposed changes to legal and ethical guidelines governing human subjects research

designed more to protect institutions than [research] participants’. Under the proposed regulations, the content of these forms would be shortened and limited to specific elements outlined in the rule—described by some as ‘essential information that a reasonable person would want to know’—with non-essential information moved into a separate appendix. The reforms would require researchers to inform research participants that biospecimens might be used for commercial profit (a move motivated by high-profile cases such as that of Henrietta Lacks), tell them whether they will be informed of clinically relevant findings, and ask them whether they are willing to be re-contacted for additional research.

Notably, ‘[t]he reforms don’t include a requirement, advocated by some commentators, for routine formal assessment of participants’ mental competency to consent and comprehension of disclosed information’.  

II. CIOMS ETHICAL GUIDELINES

CIOMS is an international non-governmental organization founded under the auspices of the World Health Organization (WHO) and the United Nations Educational, Scientific, and Cultural Organization (UNESCO) in 1949. The CIOMS guidelines are for application of the principles of the Declaration of Helsinki, ‘a statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data’, particularly in developing countries, given their socioeconomic circumstances, laws and regulations, and executive and administrative arrangements. Therefore, in addition to broader developments in biomedical research and the field of research ethics, the Executive Committee of CIOMS cites the 2013 revision of the Declaration of Helsinki as a factor in its decision to revise.

The proposed revisions to the CIOMS Guidelines were released in September 2015. CIOMS invited public comments through March 1, 2016. The Working Group will review the comments and then submit a final document to the Executive Committee of CIOMS for approval.

Much like the NPRM, the proposed CIOMS Guidelines would constitute a significant revision. The CIOMS Working Group identified the following changes:

49 Hudson & Collins, supra note 7, at 2294.
50 Emanuel, supra note 15, at 2297.
51 §—116.
52 See generally REBECCA SKLOOT, THE IMMORTAL LIFE OF HENRIETTA LACKS (2010) (describing how cells taken from Lacks were developed into the HeLa cell line); see also eg Moore v. Regents of the University of California, 793 P.2d 479 (Cal. 1990) (Mosk J. dissenting) (calling it ‘both inequitable and immoral’ that the defendants would deny Moore, whose ‘contribution to the venture is absolutely critical ... any share in the proceeds’).
53 §—116(a)–(c).
54 Emanuel, supra note 15, at 2297.
55 CIOMS, INTERNATIONAL ETHICAL GUIDELINES FOR EPIDEMIOLOGICAL STUDIES (2008).
56 WORLD MEDICAL ASSOCIATION (WMA), DECLARATION OF HELSINKI - ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS I (2013).
57 CIOMS, supra note 2, at 7.
58 See generally Paul Ndebele, The Declaration of Helsinki, 50 Years Later, 310 JAMA 2145 (2013) (describing changes in the 2013 version of the Declaration of Helsinki).
59 CIOMS, Guidelines—Public Consultation, http://www.cioms.ch/index.php/guidelines-test (accessed Jan. 4, 2016).
Most guidelines have been substantially revised. Guidelines have also been merged where possible. At the same time, new guidelines have been added to address new, pressing issues that require ethical guidance (such as disaster research or implementation research). The Working Group has also decided to merge the ‘Green Book’ (the CIOMS Guidelines for Biomedical Research, 2002) with the ‘Blue Book’ (the CIOMS Guidelines for Epidemiological Research, 2009) since the two guidelines substantially overlap each other. The scope of the guidelines has been broadened from biomedical research to health-related research with humans.60

As compared to the 2002 text, which consisted of a statement of general ethical principles, a preamble, and 21 guidelines, the proposed text contains 25 guidelines.61

It is worth noting that there has been significantly less commentary on the proposed changes to the CIOMS Guidelines than on the NPRM. Therefore, instead of commenting on the proposed changes that are the most controversial, I will highlight noteworthy changes regarding use of stored biological materials (to offer a contrast with the approach to biospecimens adopted in the NPRM), research in disasters, and finally, payment of research participants.

II.1. Use of Stored Biological Materials

Proposed Guideline 11, Use of Stored Biological Materials and Related Data, addresses the use of biological materials in research.62 Although the 2002 CIOMS Guidelines discuss use of biospecimens under Guideline 4, Individual Informed Consent, the proposed guidelines elaborate on use of stored materials at greater length.63

Specifically, proposed Guideline 11 requires that ‘[w]hen specimens are collected for research purposes, either specific informed consent for a particular use or broad informed consent for unspecified future use must be obtained from the source’.64 The proposed guideline also requires that ‘[w]hen human biological materials are left over after clinical diagnosis or treatment (so-called residual tissue) and are stored for future research, a specific or broad informed consent may be used or may be substituted by an informed opt-out procedure’ that fulfills certain conditions.65 The availability of opt-out consent—which allows for use of stored material for research unless there is an explicit objection—distinguishes the proposed CIOMS Guidelines from the NPRM. Should researchers seek to utilize biospecimens that were previously collected without obtaining informed consent for their use in future research, provisions are made for the

60 Id.

61 In the final version, the Working Group will add both introductory text and appendices. CIOMS, supra note 59, at n.p.

62 CIOMS, REVISION OF CIOMS 2002 INTERNATIONAL ETHICAL GUIDELINES FOR BIOMEDICAL RESEARCH INVOLVING HUMAN SUBJECTS: DRAFT GUIDELINES (2015), http://www.cioms.ch/images/stories/guidelines.dem/AllGuidelines-1-25.pdf (accessed Jan. 4, 2015).

63 CIOMS had revised its Guidelines for Ethical Review of Epidemiological Studies to reflect relevant issues from the biobank debate in 2005. Bernice S. Elger & Arthur L. Caplan, Consent and Anonymization in Research Involving Biobanks: Differing Terms and Norms Present Serious Barriers to an International Framework 7 EMBO Rep: 661, 662 (2006).

64 CIOMS, supra note 62, at A1

65 Id. at 31 (requiring that patients are aware of the opt-out procedure; are provided with sufficient information; are told they can withdraw their data; and have a genuine opportunity to object).
IRB to waive consent under certain conditions.\textsuperscript{66} Although similar provisions are also proposed under the NPRM, the NPRM explicitly states that such waivers of consent will be ‘rare’.\textsuperscript{67}

In proposed Guideline 11, biobanks, which are not discussed at all in the 2002 CIOMS Guidelines, ‘can only collect biological materials and related data from low resource settings in collaboration with local health authorities. The governance structure of such biobanks must have representation of the original setting... [T]here must be provisions to return all materials to the setting concerned and share possible results and benefits’. This provision reflects the CIOMS Guidelines’ particular focus on developing countries as well as general calls for collaborative partnerships to minimize the possibility of exploitation.\textsuperscript{68}

\section*{II.2. Research in Disaster Situations}

Proposed Guideline 20, Research in Disaster Situations, is entirely new, having no analogue in the 2002 Guidelines. The need for a substantive guideline such as that offered here can be found (to point to one example) in the discussion that followed the 2014 outbreak of Ebola Virus Disease in West Africa.\textsuperscript{69} At the time, it was noted that research conducted during outbreaks would be the primary, if not the sole, means of establishing efficacy of Ebola treatments and vaccines in humans, which made research not just desirable but necessary.\textsuperscript{70} Yet, the circumstances that made the outbreak difficult to contain—such as high infectivity, weak health systems, and rampant fear and mistrust—also threatened researchers’ ability to conduct meaningful clinical evaluations of experimental interventions.\textsuperscript{71} This led to debate about how to conduct socially valuable, scientifically rigorous research while also affording adequate protections to research participants.

Proposed Guideline 20 states that ‘[i]n order to identify effective ways of mitigating the health impact of disasters, health-related research must form an integral part of disaster response’.\textsuperscript{72} The guideline would require researchers, sponsors, and IRBs to ensure that studies are ‘responsive to the health needs or priorities of the disaster victims and cannot be conducted outside a disaster situation’, ‘that communities are actively engaged in study planning’, and that ‘individual informed consent of participants is obtained even in a situation of duress’.\textsuperscript{73} This important addition addresses an emerging challenge in human subjects research.

\footnotesize{\textsuperscript{66} Id. (requiring that the research would not be feasible without the waiver; that the research has important social value; and that the research proposes no more than minimal risks).\textsuperscript{67} HHS, supra note 17, at §3,944, §3,945.\textsuperscript{68} Ezekiel J. Emanuel, David Wendler & Jack Killen al., \textit{What Makes Clinical Research in Developing Countries Ethical? The Benchmarks of Ethical Research}, 189 J. Infect. Dis. 930, 932 (2004).\textsuperscript{69} See eg \textbf{WORLD HEALTH ORGANIZATION (WHO), ETHICAL CONSIDERATIONS FOR USE OF UNREGISTERED INTERVENTIONS FOR EBOLA VIRAL DISEASE: REPORT OF AN ADVISORY PANEL TO WHO (2014)}\textsuperscript{70} Steven Joffe, \textit{Evaluating Novel Therapies During the Ebola Epidemic}, 312 JAMA 1299, 1299–2000 (2014).\textsuperscript{71} See generally Jesse L. Goodman, \textit{Studying “Secret Serums”—Toward Safe, Effective Ebola Treatments}, 371 NEJM 1086 (2014).\textsuperscript{72} CIOMS, supra note 62, at 60.\textsuperscript{73} Id.}
II.3. Reimbursement and Compensation for Research Participants

The practice of offering payment to individuals in exchange for their participation in human subjects research is generally recognized as important to recruitment. Yet, the question of whether payment is a ‘necessary evil’ or legitimate compensation for services rendered remains a source of debate. Unfortunately, the various laws, regulations, and ethical guidelines that govern the conduct of human subjects research offer relatively little in the way of specific guidance about the factors and/or features that render offers of payment ethically acceptable.

Proposed Guideline 13, Reimbursement and Compensation for Research Participants, takes a strong stance on offers of payment to research participants. While the 2002 CIOMS Guidelines state that research participants ‘may be reimbursed’, proposed Guideline 13 asserts that participants ‘must be reasonably reimbursed for direct and indirect expenses incurred during the research, such as travel costs and lost earnings, and compensated reasonably for inconvenience and time spent’. As the accompanying commentary notes, ‘[p]articipants should not have to pay for making a contribution to the social good of research’. While acknowledging ethical concerns related to undue inducement, the commentary points out that ‘[e]specially when the research poses low risks, providing compensation for participating usually does not raise concerns about undue inducement’.

This proposal may be particularly useful in practice. Among those engaged in human subjects protections, there is wide agreement about the contextual nature of undue influence and the difficulty of establishing a bright line between mere and undue inducements. As a result of this difficulty, many IRBs are likely to adopt unnecessarily conservative approaches to offers of payment, which may result in under-payment and even exploitation of research participants. Therefore, proposed Guideline 11’s recognition of the need to reimburse and its effort to minimize worries about undue inducement for low-risk research is a welcome change.

III. CONCLUSION

Changes have recently been proposed to two influential documents in human subjects research: the Common Rule and the CIOMS Guidelines. The proposed changes are a response, in part, to developments in the conduct of human subjects research and a perceived need for greater protections for research participants. It is not surprising,
therefore, that some similar issues—particularly biospecimens—have garnered attention in both the NPRM and the proposed CIOMS Guidelines.

This Development was finalized after the comment periods were over but before either the final rule or guidelines were made publically available. Open questions include how long it will take for these documents to be finalized and how, if at all, the final products will differ from the proposed versions. For reasons identified above, many stakeholders in human subjects research—including myself—will likely see the final results both as an improvement over the existing documents but also as a compromise. Nevertheless, if past experience is any guide, the research community will be working with the final products for some time.