

Virtual Mentor

American Medical Association Journal of Ethics
March 2010, Volume 12, Number 3: 192-196.

JOURNAL DISCUSSION

The Physician-Researcher's Dilemma

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Manabe YC, Jacob ST, Thomas D, et al. Resurrecting the triple threat: academic social responsibility in the context of global health research. *Clin Infect Dis.* 2009;48(10):1420-1422.

At its most basic, the title of a medical doctor represents a commitment to engage with patients, helping and advising them to the best of one's ability. When the physician also takes on the role of researcher, which responsibilities have the greater claim on his or her time? While the question of allocating time between the clinic and the laboratory can be personally stressful even in the best-equipped hospitals in the U.S., in settings of extreme physician shortage it becomes a stark moral dilemma—one that is only partially addressed by current ethical frameworks.

In "Resurrecting the Triple Threat," Manabe et al. propose a framework for tackling this question by examining the work of AIDS researchers in Uganda. The HIV/AIDS pandemic has exacerbated the health problems of resource-poor countries, galvanized international research and funding bodies into action, and brought about broader concern for the human rights of the affected. Global health research has expanded rapidly in recent decades, in part through collaborations that leverage resources from richer countries to attack the problems of developing nations at sites of high disease prevalence. These collaborations answer the call for new research that could reduce widespread human suffering. Yet their rise prompts new ethical challenges, starting with the problematic power relationships of international collaborations, their history of abuses, and their present distributions of power.

The best intentions of global health work are tested when priorities set by narrow research agendas collide with realities of widespread health problems on the ground. Manabe et al. describe the case of the Infectious Diseases Institute at Makerere University in Uganda—a new academic medical center, built with the capacity for treating 13,000 HIV-positive patients while supporting world-class clinical research, with funding from both private and public sources. Next to these modern facilities is the small, chronically overburdened Mulago Hospital—a public referral center, representative of the heartbreakingly brittle health care infrastructure on which most patients in developing nations rely [1, 2]. When an American research fellow at Makerere uses her time to volunteer in a public clinic, is she postponing the outcome of her research and letting down her sponsors? Conversely, when she passes by the long lines of patients awaiting basic care at Mulago Hospital on her way to the lab at Makerere, is she ignoring an obvious medical need?

The authors approach this dilemma by drawing upon a familiar model of academic medicine: the framework of a “triple threat” career that supports at once the humanistic practice of clinical medicine, the teaching and mentorship of students, and research supported by outside funding. They argue that academic institutions concerned with global health must resist the trend to prioritize the research component, and build professional structures that make it easier for global health researchers to both treat patients and teach while working in dramatically underserved communities. In the absence of clear guidelines and institutional support, physician-researchers struggle to balance empathy and impact in ways that are both ethically acceptable and practically sustainable. This dilemma places researchers at risk for personal disengagement and burnout, and, at worst, for committing frank exploitation.

Resource-intensive research in resource-poor settings is funded by the holders of global wealth: pharmaceutical companies, major philanthropic organizations, academic institutions, governments, and supranational agencies. Thus, medical research is subject to familiar global power dynamics—the same mechanisms that keep the residents of poorer nations vulnerable to diseases and exploitation alike. Existing ethics guidelines emphasize that, for global health research to be ethical, researchers must be scrupulously cognizant of who controls the information, who bears the greatest risks, and who will ultimately benefit from the work [3, 4]. Visiting medical researchers have the responsibility to prevent further exploitation of vulnerable populations and to look for upstream causes of ill health that can be addressed through advocacy [4, 5]. In particular, academic global health ethics highlights the principles of personal humility, introspection, solidarity, and social justice, guided by awareness of the rights of individuals and communities [5]. Other formulations outline principles for designing ethical research in developing countries, reinforcing the values of collaborative partnership, fair recruitment practices, respect for local communities, scientific validity, and favorable risk-benefit ratio for participants. The more specific recommendations have focused on ethical methods of enrolling patients in trials, such as obtaining valid informed consent [3]. However, on the topic of researchers’ time allocation, the new guidelines are silent.

In the rest of this discussion, I evaluate the claim of an obligation to allocate researcher time for clinical care, using three of the four basic principles of medical ethics: beneficence, non-maleficence, and justice. (While the fourth—respect for patient autonomy—contributes to ethical concerns in global health research, especially with regard to individual versus group or community autonomy, it is less directly related to the allocation of physician time.) I then discuss the pragmatic levels on which the obligation may apply, along with the associated mechanisms of accountability and support.

Without a doubt, both research and clinical care can and do serve the principle of beneficence [6]. In fact, research arguably holds the greater potential for future

beneficence, as a breakthrough in HIV treatment or prevention could save millions of lives. At the same time, a complete exclusion of clinical work is hard to excuse, according to Manabe et al. “If we do nothing in situations where we perceive clear medical need,” the authors rightly ask, “does this constitute inflicting harm?”[1]. Physicians are trained to weigh the costs of inaction as well as those of action, and ignoring the suffering of the sick when one possesses the clinical skills to help them, along with some freedom to do so, certainly seems like a failure of non-maleficence.

In the present case, the main ethical challenge—and the one Manabe et al. address most effectively—is the matter of justice and non-exploitation. From a strict utilitarian perspective, it would seem that the researcher’s time is most efficiently invested in the laboratory or research facility, where treatments of worldwide importance are devised. This argument is especially powerful in situations of urgency, such as research on a rapidly emerging pathogen (e.g., H1N1). If the situation is examined with an eye to social or Rawlsian justice, though, the argument is reversed, and medical professionals have a positive responsibility to ensure that the needs of the sickest and most marginalized patients are not neglected [6]. In a global health setting, the principles of social justice and non-exploitation support a broad view of the visiting physician’s obligation to the entire host community. Here, preferentially rewarding pure research over clinical care can prompt the neglect of medical needs in the community while benefiting individual careers and powerful corporations, effectively committing exploitation.

Furthermore, it was recently argued by Barnhart in *Virtual Mentor* [7], that a type of brain drain occurs when an academic institution in a developing country uses its scarce teaching resources to subsidize the professional development of an American trainee instead of a comparably skilled local medical student. Even with the concomitant increase in tuition revenue, hosting professionals from a wealthy country in the short term reduces the long-term supply of caretakers to the local community [7]. This criticism easily extends to the training of researchers: although research fellows require less direct teaching than do medical students, they can still create a significant drain on the time of more experienced local faculty, administrative support, and other limited institutional resources.

Once we accept that ethical principles compel researchers to engage with the underserved community, we must tackle the pragmatic question of how this obligation can be met. Researchers must juggle three types of ethical obligations: personal (to uphold one’s moral beliefs), professional (to meet professional standards), and contractual (to satisfy the providers of funding). It is here that the “triple threat” model of professional development invoked by Manabe et al. is most useful. This model has long empowered physicians to contribute to advances in modern medicine while remaining grounded in interactions with patients and passing on their knowledge to generations of students.

In the global health context, “resurrecting the triple threat” is a call to restructure international academic partnerships with the goal of promoting greater social

responsibility; it is an invitation to see a doctor's engagement with the community through service and teaching not as distractions from research work, but as valuable components of a rewarding professional life. On the personal level, embracing this paradigm would offer physicians a framework for resolving a number of ethical problems, including that of time allocation between the lab and the clinic, and a more supportive model for personal social responsibility overall. On the professional level, the obligation to treat patients in extremely disadvantaged communities can be emphasized in initial training, institutional policies, and continuing medical education—not as a naive ideal, but as a pragmatic career component and the basis for professional respect. Finally, through regular clinical practice, researchers may gain greater insight into the community, increasing cultural competency and understanding between the academic institution and its surroundings.

The contractual element of this obligation is predictably the most complex, and crucial. Competitive academic programs are fueled by research funding, which selectively rewards time spent on research, incidentally de-prioritizing activities undertaken out of a sense of social responsibility. The mechanisms of remuneration and accountability must be restructured to help balance the contractual obligations of the academic physician with the values of medical ethics and the actual needs on the ground. If funding sources and host sites are serious about their commitment to global health, they should formalize the allocation of time between research and clinical care at their sites, much as they formalize the terms of the research itself, and include local communities in the planning process. This is obviously a challenge, but it must be viewed as an opportunity for global health institutions to organize themselves, to strengthen their relationships with their hosts, and to make an even more substantive contribution to the evolution of medical ethics.

With its privileged role in society, the medical profession has a broad responsibility to the health of the greater community—a responsibility that extends beyond the walls of the laboratory and the hospital. In settings of extreme medical need, this translates into a positive obligation to help the sickest and the poorest, even if this is not the primary goal of the institution. At the same time, a structured approach is vital: we cannot afford to frame responsibilities that are too broad to fulfill or too vague to be actionable. To do so would be a disservice to our patients and to the profession alike. By explicitly integrating the ethics of global health with the traditional ideals of academic medicine, we may arrive at a pragmatic framework for academic social responsibility—to the empowerment of institutions, doctors, and victims of disease in the most disadvantaged places in the world.

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