



Presidential Commission
for the Study of Bioethical Issues

TRANSCRIPT
International Research Panel Results and Discussion

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DR. WAGNER: In our -- thank you, Zeke. In our next section we get to hear from a couple of our commission members, Christine Grady and Nelson Michael. They served along with our chair, Amy Gutmann, and John Arras, on the international search panel, which, as Amy noted before, was set up as a subcommittee of this commission. On behalf of the entire commission, thanks to the four of you for being engaged in that.

Now, Christine and Nelson will report to us on the findings and recommendations of the subcommittee that were drafted at the conclusion of your third meeting, I believe, in July.

And according to the terms of reference for the international research panel, their task was to advise the commission in the following areas, commissioners, and that is: the dominant norms and competing alternatives driving ethics of medical research and different -- in different global regions that are outside the United States; two, conflicts, if any, between U.S. norms and international standards, something that Zeke was just talking about; three,

challenges facing researchers conducting U.S.-funded research in global settings; and four, possible strategies to address differences in regional norms for medical research.

So, with that, which of the two of you -- Nelson, you're going to begin? Welcome, and thanks for doing this.

DR. MICHAEL: Thank you, Dr. Wagner. So, I thank the commission for allowing Christine and I to

speak to you today about, I think, a very, very rich process that both of us, along with John Arras and our committee chair, Amy Gutmann, were really privileged to spend time with a large international group of colleagues. And I found it unbelievably informative. This is coming from the background of somebody who has been doing international research all my professional life. And I learned a lot from these colleagues, and I found them both professionally very engaging and helpful on this topic, and I think I've made a number of lifelong friends, as have we all, on that commission subcommittee. It was a very well-selected group.

So, the way this is going to occur, I am going to talk about the first two recommendations that have come out of the report that has been described earlier today, and Christine will then take over from me, and will describe the next three of the total of five recommendations.

So, I don't want to do much reading, so -- but I will just have you look at this, and I will read the top line sentence. So, the first recommendation was that researchers must demonstrate respect for human

subjects and their communities in all phases of clinical trial design and implementation.

Recognizing other cultural standards and practices through community engagement -- and that is the buzz word -- is one concrete means of showing respect. And here you see two sub-topics that I will talk about briefly at the very end of my remarks, in terms of increasing ongoing international dialogue between U.S. and international bodies as being a critical part to protecting human subjects, and also touching briefly on equivalent protections, which I think you are going to see as a theme multiple times here today.

So, what is community engagement? That is a very large catch term. And I think that one thing I am hoping in the next session to get from some of the presenters is their view on some of the more specific aspects of what we mean by community engagement. So this isn't just high-minded talk, it can be distilled to implementation and meaningful evaluation to see if this process truly does increase protection for research volunteers, and isn't simply a salve.

So, I see this, and the panel saw this, as a process that was additive to all of the top-down normative body and regulatory processes that are already in place, to -- and by that I mean scientific review, the institutional review board, or ethical review committee process. This is something that is additive to what is already in place. This is a bottom-up process to strengthen the transparency of research activities.

In that sense, it's a microphone. This process is a microphone from the community from which subjects are embedded to the research activities and to the researchers themselves, but also to the related communities in which all of us exist. This would include -- and tangible examples of what community engagement could be, and manifestations of those would be -- community advisory boards, open meetings to discuss research activities that are forming and are ongoing, what their implications are. These would include invitations for community representation on study teams and to bring liaisons from the community to normative bodies and non-governmental organizations.

An essential distillation of this process of community engagement, which would be research is continuously viewed and struggled with -- and I use that term pointedly -- it's struggled with -- by the broader number and type of partners that are engaged in scientific and clinical research activities to ensure that subjects and communities continue to endorse benefit outweighing risk.

So, this addresses and respects international diversity and ethics and practices. However, I think it's very, very important to say, and we spent some time talking about this as a deliberative body, that community engagement is necessary, but it is not sufficient, in and of itself, to strengthen bioethical standards, and potentially one could expose circumstances where community approaches in specific cases are actually contrary to overall views of bioethics or intrinsic rights that the majority of individuals living on this planet would endorse.

And, therefore, this process may, in fact, expose information that would lead research teams to actually decide not to do science, not to do research

in that particular time and place, and could modify that science, or even stop the process, all together.

So, in terms of specifics about community engagement, the World Health Organization, UN AIDS, and the AIDS Vaccine Advisory Coalition -- and we're very honored today to have, in the next session, to have a representative from AVAC, the executive director, Mitchell Warren, who I'm sure will be talking a little bit about good participatory practices. But this has been -- they just released a second version of this approach, so there is some granularity to, again, the high-minded comments that I am making now. I think there is a process in place to guide us to how one would actually implement and actually evaluate this process, and I will let -- I'm sure Mitchell will be talking about that to some degree.

Let me just end by pointing to these two points that are clarified here, under the first recommendation. There needs to be an increased dialogue between U.S. bioethical conversations and those which occur in the international arena. And this is, I think, most notably demonstrated by the second

point -- and this was discussed during Zeke's conversation with us, as well, about equivalent protections.

I think we need to embrace the protection of subjects over the embrace of compliance with regulations. And in that sense, I think the system needs a little more sanity so that we can concentrate on that which may be very well and good in an international norm -- an example that's given in the report is the differential application of annual continuing review processes, which are different, as an example, between the United States and the United Kingdom -- and I think that we need to be reflective on how U.S. standards and compliance to those standards may, in fact, not truly be enhancing research protections. And there needs to be a dialogue and a give-and-take in that sense, so that, ultimately, the best thing is done for research participants, either here in the United States, or overseas.

So, let me stop there and go on to the second recommendation. And this is one I don't think I need to say much about, because we discussed a lot of this,

as it worked out, just in the past few minutes.

So the second recommendation was that funders of human subjects research should support ethics training for investigators and others, to include IRB members.

Now, this is not as counterculture to discussions that we just had emphasizing protection over compliance, because part of the discussions involve the fact that, yes, we thought it was important for researchers to understand that training in bioethics isn't just a box-checking exercise, it isn't just a requirement. It needs to be something that truly is embraced, so that the scientific process can be completely integrated, and not seen as just simply an adjunct or a hurdle, in the worst case, to get over before science can be done.

Because experienced investigators will understand that even a single episode in their careers of lapses in ethical execution of science has very dire consequences, not just for individuals, but for institutions and their -- and potentially, even the entire field in which they are involved in. So this is

something that needs to be done in a way that is seen as meaningful by researchers, and not simply a burden.

In that sense, ethical training needs to be balanced, in terms of cultural differences that may exist between what is done in one's home country and what is done overseas, and the sense this research needs to be done in a context where ethical training isn't simply an onerous online series of endless training that is seen as pro forma.

But that said, as I am a person that is subject to a lot of that online endless box-checking exercises, I find very little in the current training that really has helped me to be an international researcher, and I think that that is something that, clearly, would be an important strengthening of ethical training as we go on, to focus on the implications and the differences of doing research, both in the United States as well as overseas.

So, in that sense, I think that would be a recommendation that we would have, that that kind of training be more focused and have a better rationale for the implications for doing the research overseas.

Let me just close by saying that ethical training -- and this is something I think that probably Dr. Glass will resonate with and maybe discuss -- I haven't seen your slides yet, but this is something I think that you will feel strongly about -- is I think that we need to strengthen ethical review committees and strengthen IRBs overseas.

When we talk about IRB training, we're not simply talking about box-checking exercises for individual scientists. We're talking about a way to ensure that, as we, the world community, begins to do research in more and more countries, that there is equivalent strength of IRBs.

And I will tell you that, in my own experience, the Fogarty International Center, the European EDCDP, the WHO, and some of the WHO-associated activities, like the African AIDS vaccine program, is very interested in spending their resources on ethical strengthening of ERCs and IRBs overseas.

And, importantly, that process is linked to normative bodies and oversight by groups like the World Health Organization so that, at the end of the day, it

isn't just a researcher talking to their IRB, their institution, saying, "Yes, I sent a team that was funded by the Fogarty, it went overseas, it trained this IRB, everything is fine, everything is fine now." It's never good enough for a researcher to say everything is fine. Others need to look into that process.

So, let me stop there and hand the control over to my colleague.

DR. GRADY: Okay. So I want to echo what Nelson said, that it was an honor to be part of the international panel. It was a remarkably committed, engaged, and thoughtful group of people from around the world. And under Amy's very capable leadership, and the staff's indefatigable efforts, we began our work right away and in three short days, I think, accomplished a lot.

I am going to talk about the three recommendations that are left. But I wanted to say that the recommendations reflect the discussions of the panel, and are presented to the commission now for consideration. They are not, like, "finalized," I

guess, is the way I would think about it.

And also, that they were based on a set of findings that the report also begins to describe, and I just wanted to comment on a couple of those findings, because I think they're relevant to understand the recommendations.

One of those is that the panel noted that in the decades since the Guatemala experiments, there has been a number of rules, standards, and principles that have been developed for protecting human subjects, both in the United States and across the world, and that many of these rules and standards actually agree on some fundamental principles that do protect human subjects.

Despite that agreement, there is some variation. There are some conflicts. And there are differences in implementation and interpretation that sometimes do create challenges, especially in multi-national research.

We also, of course, noted the increase in international research, which comes with both benefits and potential problems, in the sense that it's very

important for finding ways to benefit the health of people around the world, and understanding differences, but it also is true that different places have different levels of experience with protecting human subjects, and sometimes there are ways to find routes around protections.

So, to focus on the three recommendations, this is the third one that the panel came up with: Greater efforts are needed to enhance transparency, monitor ongoing research, and hold researchers and institutions responsible and accountable for violations of applicable rules, standards, and practices. To enhance transparency and accountability, governments should consider requiring all greater-than-minimal risk research to be registered, and results reported.

I think -- I don't think anyone would disagree with transparency, or the notion of transparency. We have heard about that throughout lots of our meetings. And we discussed yesterday the role of lack of transparency as a factor in the Guatemala experiments. Certainly shining a light on research makes it difficult to ignore the ethics, and allows people to

comment on the ethics.

Similarly, accountability. One of the members of the panel in particular, I think, frequently said, "It's not the fact that we lack standards and rules, but we lack or we don't have enough enforcement of them."

And I think he also included, in addition to enforcement, knowledge, that the -- as Nelson talked about, training and education of investigators and IRBs. Investigators and institutions can only be held accountable for things that they know about. The rules have to extend -- they have to be available to them, they have to know how to apply them, and they have to know what the consequences are of not adhering to them. And there are a number of consequences that we could talk about.

The specific recommendation here is about registration. And certainly it is one way of increasing transparency. I think it's notable that in the last decade or so there have been a lot of efforts to have clinical trials registered around the world. Certainly the Declaration of Helsinki says every

clinical trial must be registered in a publicly-accessible database. The WHO says registration of clinical trials is a scientific and ethical responsibility.

Our current U.S. law, as found in the Food and Drug Administration Amendments Act of 2007, requires advance registration in a public database, clinicaltrials.gov, of applicable clinical trials, which include mostly intervention studies that are under FDA regulation, and does not include a bunch of studies that one might question whether or not they should be in there. Phase one studies, for example, observational, epidemiological, and some others.

I think, interestingly, by the current definitions of clinicaltrials.gov, what is applicable -- most of the studies that were done in Guatemala, if they were being done today, would not be registered in the clinicaltrials.gov.

It's also interesting that many other jurisdictions around the world have similar public registries. The European Medicines Agency has an online registry that it's had for several years. Many

countries have established national registration requirements. Brazil has one that's been in effect for a long time, India, China.

The International Council of Medical Journal Editors require, as a condition of consideration for publication, registration in a public registry. So there is a lot of efforts already in place.

So, I found myself thinking, as I was preparing for today: What could the commission do that would advance this particular area of transparency, especially through registration? Certainly we could endorse the policies of the Declaration of Helsinki or the ICGAME -- JME, (sic) or FDA, or the European Directive, et cetera. We could think about expanding the requirements for registration, to include more clinical trials that are -- or more clinical research that is not currently covered, and we could also talk about maybe other options for encouraging or enforcing accountability and transparency beyond registration.

So, going on to --

DR. GUTMANN: Could I just quickly --

DR. GRADY: Yes?

DR. GUTMANN: You mentioned FDA, but you didn't mention NIH, which sponsors an awful lot of clinical trials.

DR. GRADY: Yes. So all clinical trials that are interventional are required to be published in clinicaltrials.gov if they're NIH trials.

The next recommendation from the panel was the United States should implement a system to compensate research subjects for research-related injuries. And we talked about one model, which I will get to in a second.

I think everyone knows that, in the United States, neither sponsors nor institutions are required to provide compensation for research injuries, or free medical care for injuries. They are only required by regulation to inform participants who are in greater-than-minimal risk research what will happen to them if they are injured. And there is a lot of debate about how that language should be phrased in consent forms and a lot of time spent on that.

Many European countries -- again, as many people know -- do mandate clinical trials insurance.

And we also know that research carries risk, some serious risk -- although serious risk and death seems to be relatively rare. We heard from Zeke and from others that we don't have data, we don't really know what the level of risk is in research.

There was an interesting study done a few years ago by the Lewin Group which looked at 102 academic medical centers in the United States to see what kind of policies they had for treating -- for offering medical care for research-related injuries to participants in their research. And well more than half offered none. They charged for treatment for injuries in the usual way, through insurance companies or directly to the participants, if they didn't have insurance. None offered compensation for anything beyond medical care, like lost wages or of pain and suffering, or anything like that.

Again, everybody knows in the U.S. the way to get compensation for research injury is through the tort system. And I think what's really interesting is if when you go back in to look at the history, decades of discussion have ensued about the need for a system

of compensation for research injury. And national commissions, one after the other for 30, 40 years, have recommended a no-fault system of some sort for compensation for research injuries.

And interestingly, although commissions have recommended it, and lots of moral justification has been written about it, no such system has been established. There are lots of interesting obstacles that we could talk about.

Again, I think it's interesting to see what's happened in the last decade. Many countries around the world and some U.S. research institutions have actually moved forward and developed compensation systems. I think there is some interesting -- I had some examples of problems that could occur, but I want to say more about what the commission's -- I mean the -- sorry, the panel's recommendation points to.

It points to the possibility of examining the vaccine injury compensation program, which is a U.S.-based no-fault alternative to the traditional tort system for compensating people who are injured from compulsory childhood vaccines. And this is a system

that is funded by a surcharge on vaccines that are pooled and available for damages. There is a list of eligible side-effects, acceptable time frame, and it covers a lot of different kinds of injuries.

There are other options for no-fault mechanisms that might be worth exploring. And I think it's really maybe important for the commission to think about what the other options are, as well as to find out more about the vaccine injury compensation system.

So, again, I thought about what should the commission do. I think, certainly, we can call for no-fault insurance, like many previous commissions have. We might be able to dig deeper and propose some tangible structures for no-fault compensation systems. Again, there are others that have been written about and proposed besides the model based on Vaccine Injury Compensation Act.

And the fifth recommendation from the panel was continued efforts to harmonize and guide interpretation of rules should be made a priority over creating new rules.

As you know, we just heard about the proposed

rule-making from the government, in terms of changing the Common Rule, which suggests that there is a need to revise and continue to update rules, even if there is not a need for more rules. But interestingly, as I was thinking about this, if I talk about registration and compensation for injury, if we were to attend to both of those, both of those might end up necessitating new rules.

I think that the panel was really in agreement -- in heated agreement, actually -- that new rules are not necessarily better. We don't need new rules. But we need sound, clear, streamlined rules that can make efficiencies and promote quality, in terms of research.

I also think it's interesting that we have -- we continue to talk about harmonization. Again, nobody, I think, disagrees with the need for harmonization. Of note, Ruth Macklin, in one of the papers that we had received, opined that harmonization is probably not feasible, and part of the reason is because there are radically different interests that the stakeholders have, in terms of research needs.

I think it's interesting to think about what kinds of harmonization we could promote, whether we should, as a commission, endorse streamlining, revision, harmonization, evidence-based protection, the promotion of a culture of responsibility using the rules that do exist. I mean there are lots of possible ways to go forward. But I think the goal is efficiency, protection, and harmonization.

And that is all I was going to say.

DR. WAGNER: Christine, thank you. And Nelson -- and Nita has a question.

DR. FARAHANY: First, thank you both. This was incredibly informative. And thank you, all of you, for participating in what sounds like an incredibly productive process.

I wanted to focus, Christine, on recommendation number four about the no-fault, or strict liability system. And you know, it strikes me as a challenging one, particularly given the number of past commissions that have recommended it, but also as a person who teaches tort law, and is somewhat committed to the tort system, it seems at odds with the

National Vaccine Act approach.

So, the National Vaccine Act is actually a compulsory process, versus an assumption of the risk that people undertake with engaging in human subjects research. And so, it seems, theoretically, at least, different to me, if you choose to engage in research.

And it seems like it dovetails with another discussion that we have been having, which is what are the benefits of research to individuals and to the community. And thinking about how you balance the benefits of research versus the risks of research that might pose to an individual, this might be one of those areas of benefits of research that we would think about, which is what is the compensation for the risk, or how do you overcome the risk.

It might be different, though, as well, right? We might think the benefits of engaging in research, both to the community and the individual, are sufficient such that a strict liability system weighs heavily against the researchers, and more in favor of the individual. So it seems like this is a delicate and difficult area.

So, I was hoping you could elaborate a little bit about the rationale for a strict liability system, and for thinking about, given that this is an assumption of the risk -- and one of the things, of course, that we promote is informed consent and the need for informed consent -- how those work together.

DR. GRADY: I probably can't, but I can say a few things that I think are maybe relevant to that question, Nita.

I think the panel, for example, talked very briefly about the vaccine injury compensation program. There has been, however, some literature that has addressed this as a possible model for research-related injury.

And I think, you know, there are lots of reasons that it works okay in the vaccine world and might not work so well in the research world. One of them is that the -- you know, there are a limited list of vaccines that are predictable, to some extent, in terms of what their side-effects are. And they are compulsory, as you suggested, in a certain way, although some would argue with that.

The other is that, you know, research is -- I mean we do have this system where we ask people to accept the risks of research, and they have the choice to not accept those risks. And some people have argued, once you have done that, you don't need to offer them the benefit of care for their research-related injuries, that, you know, that's part of what they bargained for, so to speak. But that seems -- I don't -- that doesn't seem right to me. I mean I have to say I think --

DR. GUTMANN: One thing. The international panel felt strongly that it was wrong and a mistake that the United States was an outlier in not specifying any system for compensation for research subjects, other than you get a lawyer and sue. And most research subjects just -- it's just too difficult to do it. It's much more difficult than in the case of a -- you know, somebody hits you with a car and you -- there are lawyers who come and, you know -- what are called ambulance chasers, and you can do it.

The -- where -- the U.S. is an outlier here. What -- and it doesn't mean that there aren't arguments

to be made, but the panel felt very strongly it was an outlier on the wrong side.

What the panel did not feel strongly about is what the right mechanism would be. It used the vaccine example as an example of something that works in its area and is available, but it did not specify. And in some future meeting we will explore possibilities. But the strong point of the panel was not to have rules about compensation for certain kinds of injury is a bad thing.

DR. FARAHANY: And just to clear up that, so the strong recommendation is not that it be a strict liability scheme, just that some scheme be developed?

DR. GUTMANN: Absolutely right. There is not a strong recommendation about what the scheme should be. There is a very strong recommendation that there ought to be some understanding of having a scheme for -- a system for compensation.

And there was also a sense that, although previous commissions have recommended this, they have recommended it among one among, in some cases, dozens of recommendations, and have not highlighted this, and

have not gone into any depth, which is what the panel is asking us to do, on what such a scheme might look like.

So the panel is asking us to make this a priority among the things we look at, and look at it in some depth.

DR. WAGNER: But, Nita, you're suggesting it as the commission -- is we incorporate this in our recommendations going forward, we should consider recommending against strict liability system?

DR. FARAHANY: I want to think about it more carefully. I mean this is -- but I -- my intuition would be that a pure strict liability scheme in a system like this one would probably not be the appropriate one.

But I am open to that being something --

DR. WAGNER: It's a conversation the committee should --

DR. FARAHANY: It's a conversation we should have, yeah.

DR. ARRAS: As a fortunate member of this team, I just want to make a comment about the framing

of this report, okay, because this report leaves out a number of really hot-button issues in the world of international research; issues that have drawn a lot of heated discussion. For example, the standard of care and the use of placebos in trials, the provision of post-trial access to drugs, and what that should look like, or the provision of ancillary care during a vaccine trial.

So these are all very contentious, contested issues, and I just think it's important to note, for the commission and for the broader public, that, given the limited time frame that our group was facing, we decided to bracket those questions and focus exclusively in our report on issues closer to the bone of protecting subjects from risk and harm and offenses to dignity. Right?

But, with any luck and more time, the larger commission will hopefully address some of those other issues, which I think are extremely important, and we could shed light on. Thanks.

DR. WAGNER: Roger, got you. But this might be a place to insert Joseph Millum's question. He is

at NIH, where he is a bioethicist. But he recalls that, with regard to equivalent protections -- and I don't know which one of you to go to on this, or anyone from that group -- that in 2003 there was a working group that reported a proposed method for deliberating -- excuse me, for determining whether foreign regulations offered equivalent protections.

And the question is are we aware of that, and why has it not gone forward, if we are aware of it?

DR. MICHAEL: Let me defer to Christine, because this is something that's very close to her.

DR. GRADY: Well, we are aware of that, Joe.

(Laughter.)

DR. GRADY: It hasn't been adopted by the regulators. And, therefore, either it needs to be adopted or revisited, and maybe more detail needs to be put into place.

But I think Zeke's point also is very important. You know, a lot of people over the years have agreed that equivalent protections ought to be -- that quote, that possibility in the regulations ought to be utilized, but it has never been fleshed out

sufficiently to allow it to be utilized.

DR. WAGNER: So it has to be further --

DR. GRADY: Well, I think that that report that Joe referred to, if we're going to pursue equivalent protections, we would look at that report in some detail and say, "What, from that report, can we salvage and say, 'This ought to be done now,' and what needs to be changed, since now we're in 2011, besides -- from 2003" --

DR. GUTMANN: Could I ask a specific question about equivalent protections? So we were given, on the panel -- and, mind you, everything we did on the panel we said was going to be a prologue to what the commission did in some more -- in some cases, in some more depth.

So, we were given one example of what an equivalent protection would be, which is in the United Kingdom the reporting is less frequent than the reporting requirement in this country. But otherwise, there is no substantive difference. And that should be seen as an equivalent set of protections. They agree on informed consent, on all the other important things

on equivalent protections.

Is there any other example? Because we need to -- if we're going to go down the road of equivalent protections, we ought to -- we've got to start by cases.

DR. GRADY: Right.

DR. GUTMANN: Of where, intuitively at least, you would say, "Sure, that's equivalent."

DR. GRADY: Yeah.

DR. GUTMANN: Is there another example, or is that it?

DR. GRADY: Well, I think I probably provided that example. It was annual review, the need for annual review. But I'm sure there are other examples. I'm not sure I can come up with one right now, but I'm sure there are other --

DR. GUTMANN: So one of the things we should do as a commission is ask those who have come before to provide us with at least a short list of equivalent protections, and we should look at them and see whether they strike us as equivalent. And if they do, then we may have a recommendation to be made. But if they

don't, this may -- there may not be equivalent -- I don't know.

DR. WAGNER: Essentially, an --

DR. GUTMANN: I am totally agnostic, because that's the only example that I have actually been given.

I mean another example -- no, one other example are different ways of obtaining informed consent, different forms for informed consent, which are basically the same, but just are different forms.

DR. WAGNER: Formatting.

DR. GUTMANN: Yeah.

DR. GRADY: I think one of the debates has been to what extent do procedures need to be equivalent, the procedures for review, approval, consent, et cetera.

DR. WAGNER: As opposed to purposes.

DR. GRADY: As opposed to principles or any more substantive requirements.

DR. GUTMANN: Yeah, yeah. So we need -- we just need some of the examples.

DR. WAGNER: Raju?

DR. KUCHERLAPATI: Thanks, Jim.

I have, actually, questions about many of the recommendations. So maybe I would focus first on the first two recommendations, Nelson. And the first recommendation is about community engagement, and the second recommendation is about training.

The way the recommendations are, you know, worded right now seem to suggest that, you know, such community engagement doesn't exist today and, similarly, that -- it also suggests that training, you know, the IRBs and the investigators, about -- you know, doesn't exist. And I wanted to make sure that that wasn't the intention. Or -- I'm not sure that -- I would imagine that there are, indeed -- there is community engagement today. It may not be adequate, I don't know what the recommendation is. Can you clarify that?

DR. MICHAEL: No, I think that's very helpful. And I find -- you know, it's provocative that you would read it that way. That certainly was not the intent. So I think that's an important thing to hear, that you would see it as -- in that light.

Certainly training exists, and certainly community engagement exists, but it's differentially applied, and it's differentially effective. And I think that is -- really was the point, to emphasize in both of those arenas, that community engagement, honestly, is something that I think 10 years ago people just shrugged their shoulders about. You know, Father knows best. The research pushes down community engagement as a megaphone from researchers to the communities that tell them what researchers or health ministries want to do. And I think the historical record may suggest some of those activities 60 years ago.

This is not to say that these activities don't exist today, but they need to be strengthened and made more transparent and more pervasive. And I think that probably Mitchell and others maybe in the next session will provide a little more granularity about what we actually mean by community engagement.

But I will tell you that in my organization, it's been a real uphill process to get hard-core clinical investigators to want to talk about things

that sound, frankly, fuzzy and soft, but understanding that there are significant liabilities, I would say, to do research overseas in the absence of really embracing the substance of both of those issues.

DR. WAGNER: We have a comment. Is it Carla Saenz? Is that the proper pronunciation in the --

DR. GUTMANN: Carlos, could you stand up?

DR. WAGNER: Carla.

DR. GUTMANN: Oh, Carla.

DR. WAGNER: Carla, yeah.

DR. GUTMANN: Carla.

DR. WAGNER: From the Pan American Health Organization, who offers this comment, which I think is an important comment to take into consideration, that their organization welcomes the recommendation to increase training in research ethics.

They want, however, to point out that what is needed is training that is effective -- that is, that targets the real needs, and also in the context of the region, even though the broad needs are the same throughout the world -- and also training that is efficient, that is coordinated with all other national,

international initiatives. Often, training -- her experience is that training in Latin America is neither.

So, we may want to incorporate these kinds of thoughts in a recommendation going forward, not that -- just that training exist, but are there some ways to gauge how it is both effective and efficient, in doing so.

We are actually probably at a good place for a break. We ran a little long because we ran long in the early session. It would be great to get back here at quarter of, so we could start again. Thanks, Nelson and Christine, for your presentation.

(Applause.)