

Wenner, D.M. (2018) "The Social Value Requirement in Research: From the Transactional to the Basic Structure Model of Stakeholder Obligations," *Hastings Center Report* 48(6): 25-32. DOI: 10.1002/hast.934

This is a pre-print of a published manuscript. When citing, please refer to the final, published version.

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The Social Value Requirement in Research: From the Transactional to the Basic Structure Model of Stakeholder Obligations

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The history of research ethics is frequently described as “reactive”. Many key developments in the field, such as the adoption of the Nuremburg Code and passage by the US Congress of the National Research Act, were in direct response to the use and abuse of research subjects. Over the years, research ethics promulgations have proliferated in the form of both national regulatory structures as well as guidance documents issued by national and international organizations. The origins of many of the proffered norms in the historical abuse of research subjects has naturally oriented a substantial portion of ethics guidance towards the protection of human research participants.

This orientation towards the protection of research subjects has also largely shaped conversations about ethical norms that don’t neatly fit into a rubric of “human subjects protections” but which are nevertheless seen as fundamental ethical dictates. In particular, debates about the so-called “social value requirement” for clinical research have been substantially influenced by this orientation.

The social value requirement (or “SVR”) says simply that clinical research with human subjects is ethical only if it holds out the prospect of producing socially valuable knowledge. It is a tenet that has been codified in a wide range of guidance and regulatory documents governing human subjects research, stretching back to the Nuremburg Code¹ and the Belmont Report.² Over time it has been included in national oversight documents in various nations, and has appeared in one form or another in repeated versions of both the Declaration of Helsinki³

and the CIOMS guidelines.⁴ Emanuel and colleagues listed it as one of seven requirements for ethical research in a discipline-defining paper.⁵

Despite its prolificacy, acceptance of this dictum was largely uncritical until recent years. Earlier discussions focused on the content of the requirement, seeking to define “social value” in the relevant sense.⁶ I have defended a view of the SVR that locates the social value of research in the likelihood that the knowledge generated will change expected social utility functions sufficiently to alter the outcomes of public policy or other health- or research-related decision-making.⁷ But not until a pair of largely consonant but separate papers from Alan Wertheimer and David Resnik has the research ethics community engaged in sustained dialogue about what seems an important prior point: the ethical foundations for asserting the requirement itself.⁸

In this paper I seek to clarify the terms of this more foundational debate. In particular, it is my contention that much of this discussion – both critiques of SVR as well as recent defenses – is predicated on a particular framework of research ethics that I refer to as the transactional model of stakeholder obligations. I argue that this model is insufficient to capture the relevant ethical considerations that ought to inform the design and conduct of clinical research, and instead introduce and defend an alternative framework that I call the basic structure model of stakeholder obligations. The basic structure model is grounded in a claim that clinical research plays a direct role in establishing the justice or injustice of our social organization, and thus ought to be governed more explicitly by justice-based considerations. As such, it is a model that explicitly accounts for the fundamentally social nature of the research enterprise itself. In addition to defending the basic structure model, I also show how it provides a more stable

foundation for the SVR, and then consider some worries about whether the model I propose may ultimately be too demanding in practice.

1: The Transactional Model of Stakeholder Obligations

Wertheimer and Resnik each independently take issue with the most commonly asserted grounds for the SVR: that researchers and research sponsors have an obligation to be responsible stewards of limited research resources, and that restricting research to that of social value can help to protect research participants from being exploited. In this section, I'll argue that Wertheimer and Resnik, as well as those seeking to defend the SVR from their criticisms, assume a particular model of research stakeholder obligations, what I call the transactional model. I go on in the next section to demonstrate why this model is insufficient to the task of ensuring research is ethical.

Both Wertheimer and Resnik argue that the scope of obligations of responsible stewardship is ultimately rather small. Although it may be unethical to devote limited public research resources to research of limited social value, private entities can use their resources as they choose as long as other strictures of research ethics are abided. In other words, while the public has a claim to value in the use of scarce resources drawn from public coffers, there is “no reason to think that the use of private resources or commercial research must meet a similar test.”⁹

The claim that the social value requirement functions to protect research participants from potential exploitation by ensuring that they are not asked to take on the risks and burdens of trial participation without the expectation that the research will produce social value also ultimately fails. In fact, as Wertheimer points out, the production of social value is neither

necessary nor sufficient to protect participants from exploitation, if exploitation is understood as a form of unfairness in the distribution of the benefits and burdens of an interaction. Social value is insufficient to protect participants from exploitation because participants may be entitled to some fair level of compensation even if a trial produces a great deal of social value. And it's unnecessary because payments to participants can always be increased, and at some level of compensation the claim of exploitation must fall away regardless of the existence of social benefits.¹⁰

In a view that has largely permeated the research ethics literature, Wertheimer explicitly conceives of clinical research as ultimately a transaction between researchers, sponsor, and research participants. On this view, protections such as prospective risk/benefit assessment and ethical oversight are justified due only to the inability of otherwise competent adults to protect their own interests in clinical trials given asymmetries in biomedical knowledge.¹¹ Within this framework, the imposition of something like the SVR is viewed as an unjust restriction of transactions between consenting adults. If a private entity such as a pharmaceutical company wishes to conduct research of dubious social value, but is able to recruit fully capacitated adults to voluntarily and with full knowledge participate in that research, interference from the state, an oversight body, or the proliferation of various professional and ethical standards intended to prevent such interactions appears impermissibly paternalistic.

Recent attempts to defend the SVR have implicitly accepted this transactional model of stakeholder obligations, in which the relevant questions to ask concern whether all parties to a

transaction are providing morally transformative consent, and whether each is receiving a fair share of the social surplus created by the interaction.

In response to Wertheimer and Resnik's dismissals of the responsible stewardship argument, for example, David Wendler and Annett Rid highlight that not only is roughly one third of clinical research publicly funded, the remaining two thirds itself is heavily dependent on public investments. Most corporate pharmaceutical research piggybacks on conceptual, first-in-human, and early-phase testing funded by public agencies. That these basic research data are then built upon by private interests in order to generate marketable interventions is the direct result of intentional policy designed to hasten the translational process from bench to bedside.

Moreover, even if we suppose that some research *is* entirely privately funded from the bench through to the bedside, such fully-privately funded research nevertheless relies heavily on social investments that have been made at every level of research infrastructure. All research is conducted against a background of public healthcare infrastructure that consists not only of physical, but also conceptual and human resources. Society makes significant investments in the education and training of physicians, investigators, and other trial staff, for example. Similarly, governments support biomedical progress through research oversight and approval processes that function to protect the public from poorly established or harmful interventions being disseminated into practice. All of this social investment, taken together, provides strong support for an obligation for even private research entities to responsibly steward the research resources available to them. Per Wendler and Rid, one way to ensure this responsible stewardship is to require that research generate social value.¹²

Wendler and Rid make valid points, and it is not my intention here to argue against them. Rather, my goal is to highlight that their defense of the SVR remains situated squarely within the transactional model of stakeholder obligations. Its normative force comes from an attempt to expand our understanding of who the relevant parties are to the transaction. In this case, they seek to demonstrate that society, via the public's investment in research, research infrastructure, and the development of trialists and shared conceptual schema, are transactors in the relevant sense and so should have standing to influence the shape of the transaction and receive an appropriate share of the benefits from it.

Other arguments offered by Wendler and Rid are similarly couched in transactional concerns, appealing either to the distribution of benefits and burdens generated by the interaction or the need for morally transformative consent or an appropriate alternative. For example, they argue that the SVR can help to protect research participants from potential deception. Since many research participants decide to participate on the basis of altruism or a desire to benefit future patients, research without social value may be playing on those desires in a dishonest way. They also argue that every justification of net risk research with participants who cannot consent for themselves is grounded in some way in the social value of the research being conducted – such as by appeal to the benefits of participating in the system to which participants contribute by engaging in net risk research.

The case made by Wendler and Rid is that individually, each of their arguments justifies the imposition of something like the SVR in some subset of cases, but jointly they support SVR as a universal requirement for ethical research. My claim is that although each of their arguments has merit, they nevertheless each seek to justify the SVR from within the

transactional model of stakeholder obligations, conceptualizing the ethical responsibilities of researchers and sponsors as grounded entirely in the ethics of free and fair transactions. It is this grounding that I will go on to challenge.

However, before moving on to critique the transactional model, there is one additional argument I want to consider, one that claims that the SVR contributes to maintaining the public's trust in the research enterprise. As I have presented the transactional model, it is easy to see why norms of research ethics are often conceptualized as paternalistic in nature. But Alex London has made the case that ethical constraints on the design and conduct of research may also be in the interests of sponsors and investigators. Maintenance of the public trust in the research endeavor is something that each individual investigator and research sponsor has reason to promote – social trust in the enterprise is what enables the recruitment of participants, public investment in basic research, and the place of researchers and research institutions at the forefront of scientific progress. However, maintaining that social trust is a kind of collective action problem. Insofar as ensuring that trust is not eroded is a matter of constraining research and researchers in ways that impose costs on researchers and sponsors, individual researchers and sponsors have rational, self-interested reasons to opt out of those constraints and allow the costs of trust preservation to be borne by others. If left unregulated, the combined self-interested actions of individual stakeholders will eventually lead to all shirking ethical norms and an erosion of public trust that will harm all researchers and investigators. There are thus self-interested reasons for investigators and research sponsors to support efforts towards research oversight.¹³

London considers that there are at least four kinds of problems with the potential to undermine social trust in the research enterprise, one important one being research that lacks social value. Later work by Felicitas Holzer expands upon this claim.¹⁴ In each case, the argument is that investigators and research sponsors have self-interested reasons to favor an SVR, as the public realization that research is not promoting or producing socially valuable knowledge may contribute to erosion of social trust in much the same way as a failure to observe other ethical constraints may.

The non-paternalistic framework as developed by London and deployed by others pushes against the transactional model insofar as it eschews the idea that research ethics is primarily about the protection of research subjects. But it nevertheless fails to challenge what is the more central component of the transactional model, namely, that the research enterprise is fundamentally comprised of transactions between consenting parties for mutual gain. Instead, it takes this view of transactions for mutual gain for granted, and provides an account of why some of the parties to those transactions have self-interested reasons to see restrictions imposed on what shape those transactions can take. So while this approach attempts to situate the SVR with respect to the public that research ultimately impacts, at the end of the day the justification for the restriction still resides in the interests of those who are construed as parties to the transaction. And while this reasoning, too, has merit it makes the SVR empirically contingent on the need for social value to preserve the public trust.¹⁵ Wendler and Rid take this empirical contingency as a reason to exercise caution and impose the SVR in the absence of evidence suggesting that the lack of social value would not undermine public trust.¹⁶ But note

that on this account, if it turns out that social value isn't necessary to maintain that trust in the research enterprise, the requirement would fall away.

2: Limits to the Transactional Model

The fundamental problem with the transactional model is that although there is some discussion regarding who the relevant parties are to a given research transaction, it takes those parties to be the only ones with moral standing to challenge its terms. The appeal of this understanding of research interactions is not difficult to understand when considered against the background context of a market ideology in which individual actors are taken to be, by and large, the arbiters of their own well-being and responsible for the outcomes of their individual, well-informed decisions. In this section I'll argue that this model is insufficient to capture all of the relevant moral considerations that bear on the design and conduct of research, for two reasons. First, clinical research has significant downstream impacts on those who cannot be construed as parties to research transactions, regardless of how broad our interpretation of the relevant parties is. And second, building on that, many (perhaps most) of those who are not parties to research transactions but who are nevertheless significantly impacted by them are constrained by those downstream effects regardless of whether or not they choose to be. There is no ability to opt out of health care systems that are – by design – driven by the results of health research.

One way to see how the transactional model of stakeholder obligations begins to break down is to consider the moral status of externalities – especially as they become broader and more impactful. As more parties external to a transaction are impacted by its terms, and as the magnitude of those impacts become larger, the plausibility of the claim that only the

transacting parties have moral standing to influence the terms of that agreement is considerably undermined.

Consider the allocation of responsibility for environmental harms. By and large, individual firms are permitted to operate in their pursuit of profit without regard for any other than their shareholders and their customers. However, when a firm's operations poison a community's water supply, the firm takes on new obligations to those who are harmed by the pollution. In this way, externalities often ground the claims of parties external to a transaction to moral consideration by those engaging in that transaction. This is the case particularly because those impacted by externalities cannot accurately be construed as "parties to" the relevant transactions: unlike those engaging in consensual interaction for mutual benefits, those impacted by externalities do not have the opportunity to "opt out". Rather, externalities are imposed on them whether or not they agree to the terms – or even the existence – of the initial transaction.

Clinical research generates many unintended consequences that look like externalities. A successful or unsuccessful clinical trial can influence which other research programs are engaged in by third parties, whether talented research personnel are willing to focus on a particular intervention or procedure, and how both public and private institutions come to view particular fields.¹⁷ Each of these impacts can be harmful – to specific researchers, to research programs, and even to members of society if a promising line of research is cut short before it is able to come to fruition.

It's important to note, however, that the presence of harmful externalities doesn't have to move us outside of the transactional model. Rather, harmful externalities are typically used

to ground claims of recompense on the part of those who are harmed by other parties' transactions. Importantly, this need entail neither that those impacted by externalities can influence the terms of the initial agreement, nor that those owed recompense are able to dictate the specific form that recompense takes. Characterizing the impacts of clinical research on third parties as mere externalities would therefore not be sufficient to justify the SVR.

I want to make a stronger claim. Many (perhaps most) of the impacts of clinical research on health systems are not simply "externalities". They are, rather, fully intended consequences of the research enterprise. Where the transactional model begins to break down as externalities become larger, it fails when so-called externalities are actually the intended outcomes of an interaction.

The results of clinical research are used intentionally by both researchers and sponsors to impact public health policy decision-making, healthcare spending, and the treatment and prescribing habits of physicians. Successful clinical trials are leveraged to influence practice in a number of ways: trial results are submitted to oversight bodies in support of marketing applications and they are published in medical journals, whose primary audience are practicing physicians. The companies whose products are studied in that subset of "privately-funded research" that some believe should be immune from an SVR actively lobby and woo physicians in order to drive prescribing practices. And the uptake of interventions into the clinic has lasting implications for health systems: states with publicly funded health systems absorb the costs of new interventions via taxation, while states with private healthcare systems pass much of the costs to patients directly at the point of care. This imposition of costs goes hand in hand with the diversion of resources away from other healthcare options. Both public and private

health systems are confronted with decisions regarding how best to prioritize spending, and clinical research is used – and is intended to be used – to buttress these decisions as well. For-profit research entities not only *intend* to impact health systems, they *must* do so in order to make a return on their R&D investments.

Importantly, the patients who are impacted by the influence of the clinical research enterprise on medical practice are like those who are impacted by externalities: they cannot be properly construed as parties to the research transaction. Patients cannot choose to “opt out” of their local health system being driven by the results of health research as published in medical journals, approved by regulatory agencies for marketing, or disseminated into clinical practice by continuing medical education. But equally importantly, those impacts on health systems cannot be construed as externalities – they are not accidental, or “foreseen but unintended consequences”. Changing medical practice is the basic motivation behind the vast majority of both publicly- and privately-funded research. Given that research stakeholders conduct their research with the intention of altering the health systems within which non-participants are required to access their healthcare, the conception of research as a transaction between sponsors, investigators, and trial participants is inadequate for understanding the ethical obligations of research stakeholders.

Despite the hegemony of the transactional model, there is growing evidence of recognition of its inadequacy within research ethics. Guideline 1 of the 2016 revision of CIOMS, for example, explicitly appeals to the use that is made of research-generated information in decision-making that is impactful for a broad range of stakeholders.¹⁸ Similarly, ongoing pressure to broaden the applicability of research results by including, for example, pregnant

women is appealing to underlying justice issues that cannot be captured from within the transactional model alone.¹⁹ And while I have above argued that London's work remains within the transactional paradigm due to its focus on self-interested reasons parties to research transactions might have for supporting substantive restrictions on those transactions, the theme of the social impacts of research is nevertheless a constant in much of his work such that he might be interpreted as rejecting this framework.²⁰

This is by no means an exhaustive list. Although the transactional model continues to dominate research ethics discussions – especially those couched in concerns about exploitation – many scholars are pushing against the bounds of this model, and even stepping outside of it. What is so far lacking is a sustained defense of an alternative framework that can accommodate these various movements within the field. In the remainder of the paper, I seek to enunciate such an alternative – one that explicitly grounds stakeholder obligations in the social role of the research enterprise and which is also able to offer a more robust ground for the SVR.

3: The Basic Structure Model of Stakeholder Obligations

The primary justification for the SVR lies not in the ethics of free and fair transactions, but rather in the goals of the clinical research enterprise and the nature of its impacts on society. In this section I introduce and defend what I call the basic structure model of stakeholder obligations. Specifically, I argue that the reasons that support organizing the basic structure of society according to demands of justice apply just as forcefully to the research enterprise as they do to other fundamental social institutions. On this view, the SVR is justified as a means of ensuring that biomedical progress occurs in a manner constrained by considerations of justice.

John Rawls emphasized that principles of justice are best applied at the level of the basic structure of society. What, exactly, constitutes the basic structure in Rawlsian terms is a matter of some controversy,²¹ but the notion is intended to capture the “major social institutions [that] distribute fundamental rights and duties and determine the division of advantages from social cooperation.”²² Major institutions of this kind thus include such varied aspects of the social order as “the legal protection of freedom of thought and liberty of conscience, competitive markets, private property in the means of production, and the monogamous family.”²³

More important than his definition of the basic structure are the reasons Rawls offered for considering basic structure institutions to be the appropriate loci of justice. Specifically, he argued that such institutions should be subject to principles of justice due to the important role they play in preserving background justice and the impacts such structures have on those who live within them. Here, I argue that the same reasons apply to the clinical research enterprise. In particular, given the inability of those impacted by clinical research to opt out of its impacts, and given the central role that the social availability, accessibility, and even mere presence of particular interventions plays in individual well-being, the transactional model of stakeholder obligations should be replaced by a model that identifies the clinical research enterprise as analogous to basic structure institutions in those ways relevant to the assignment of justice-based social obligations.

The special importance of the basic structure is grounded in two lines of thought. First, justice can't be ensured by the application of principles that only regulate individual interactions. This is because even against just background conditions, a series of free and fair transactions governed by transaction-specific rules can eventually erode the background

conditions that allow individual interactions to be fair. As resources accumulate in some hands, imbalances in wealth and bargaining power contribute to the likelihood that further accumulation will occur. As those imbalances grow, the outcomes of future transactions reflect less the free interaction of participants and more the ability of one party to leverage their disproportionate share of resources to drive their desired outcome.²⁴

Second, the life prospects of individuals – their goals, their desires, and the kinds of lives they can lead – are profoundly impacted by basic institutional structures and how they allow for their social class of origin, their native endowments, and their good or ill fortune to impact outcomes. Governance by the basic structure is a given. Individuals cannot in any real way “opt out” of the impacts that major social institutions have on their lives. How the basic structure is organized is therefore different from individual transactions in that the shape of the basic structure is not dictated by free agreements entered into with expectations of mutual benefit. Individuals aren’t given an option of accepting or not accepting the shape of the basic structure. And since the rules of the basic structure are often coercively enforced, the demand to justify its imposition is significantly increased.²⁵

The clinical research enterprise can be seen as akin to other institutions more commonly included under the rubric of the basic structure insofar as it is characterized by both of these features. First, permitting health research to be driven primarily by unconstrained market interactions has led to a predictable accumulation of market power in a very few hands. Pharmaceutical companies pursue lines of research and development that are seen to be most profitable, to the detriment of biomedical progress that would actually function to address the most pressing health needs or to reduce health inequalities. This is evident from a cursory look

at pharmaceutical development. A disproportionate share of research resources is invested in the development and marketing of new interventions which aren't particularly innovative. In a review of 25 years of pharmaceutical research, close to 70% of new products entering the market were "me too" drugs which presented little or no therapeutic gain over what was already available on the market.²⁶ A recent review of four US FDA programs for expedited review of new pharmaceuticals found that 20% of drugs using one or more expedited program and 41% of drugs that used no expedited review offered zero or negative incremental health gains over older interventions already available on the market.²⁷

It is also the case that diseases that make up a small piece of the global disease burden receive a disproportionate share of research monies. In a recent review of medical journal publications, conditions commonly found in high-income settings generated significantly more research than those responsible for most disease burden in low- and middle-income countries.²⁸ There are vast market incentives that research sponsors have to focus on diseases which disproportionately affect those in wealthier nations, despite the relatively small proportion of the global disease burden represented by those conditions.

A pharmaceutical development market constrained only by rules designed to ensure individual transactions are free and fair will naturally pull towards the development of those interventions that can be most profitably marketed, regardless of any incremental health gains offered and regardless of the distribution of those gains. The result is a pharmaceutical market saturated with ever more expensive interventions that can be marketed to physicians and patients in high-income nations as the best and newest thing even while offering little to no benefit above existing, cheaper interventions. This corresponds both to an increasing share of

healthcare resources being devoted to ever higher drug costs and relatively little investment in breakthrough interventions designed to cure diseases endemic in low-income populations or to address neglected or rare conditions. Pharmaceutical companies effectively dictate the direction of health progress via their willingness or lack of willingness to invest in research in particular areas. Each of these trends contributes to the perpetuation of drastic inequalities in access to health and healthcare, inequalities that themselves constitute injustice, but which also contribute to other forms of background injustice and further entrench the ability of certain actors to dictate the direction of development without regard to the impacts on or interests of other stakeholders.

Second, all researchers seek to circulate their research results among professional spheres consisting of practicing physicians, public health officials, policy-makers, and regulatory bodies. Without these complimentary efforts, clinical research would be a wasted investment. But importantly, it is generally not up to individual patients how the results of clinical research will impact the health care that is available to them or the health systems to which they have access. Rather, individuals exist within the context of a particular health system, whose impacts on their lives they have minimal power to mitigate.

Despite their lack of input into the way the research enterprise impacts local health systems and the healthcare that is available to them, these impacts nevertheless have a deep and lasting effect on the life prospects of all members of a community. The nature and form of healthcare access available to individuals impacts not only their individual health outcomes, but also virtually every other aspect of life. Among other impacts, health deficits contribute to missed school and work, lost wages, increased economic and personal burdens related to care,

and decreased life expectancy. Given the significance of these impacts, citizens arguably have moral standing to claim consideration in the determination of which questions are studied and how those studies are used to benefit themselves, their communities, and the health systems within which they participate. And importantly, those claims can be grounded not only in accounts of transactional fairness, but also in the basic moral claim to live within a just institutional structure.

The correct model of the research enterprise is the basic structure model: Clinical research is one aspect of an institutional structure governing the health systems that are available to individuals, an institutional structure from which they cannot opt out, and which will have deep and lasting impacts on their life prospects, their final ends and purposes, and the way that they think of themselves. As such, stakeholders in the research enterprise have obligations not only to those who directly interact with research as sponsors, investigators, and participants, but also to those who are governed by the institutional structure of which clinical research is a central part.

It is here that we can locate the normative force of the SVR: given the intentional and deeply impactful influence that the research enterprise has on an institutional structure that itself plays a deep and impactful role in determining the life chances of all members of society, the enterprise itself ought to be constrained to use in ways that are of social value. This is not an obligation rooted in a transactional model of consent and mutual benefit, but rather one grounded in the role that the basic institutions play in the lives of all members of society.

4: Research Risks and the Strength and Scope of the Social Value Requirement

The ability to produce knowledge of social value is often taken to play a justificatory role in human subjects research. Specifically, that society can expect to gain important insights from the knowledge generated in a clinical trial is sometimes taken to justify the intentional subjection of trial participants to risks of harms both known and unknown.²⁹ Given this association with the justification of risk, one natural conclusion is that the obligation to produce social value (or to expect to produce social value) varies with the level of risk that research participants are subjected to.³⁰ If social value plays this justificatory role, then we might think that the demandingness of the SVR ought vary with respect to the level of risk that participants are asked to endure (and perhaps at the extreme, the requirement should fall away altogether).

The account I have offered is consistent with expected social value functioning to justify the imposition of risks on trial participants. However, a natural upshot of the argument as I have presented it is that the SVR does not fall away or become less demanding in the absence or minimizing of risk. This is because the downstream implications of clinical research persist regardless of the risk levels of any given study. Take, for example, a head to head trial of a me-too drug with an existing, effective intervention. We might think the risks in such a trial are fairly low, since the control arm involves an established standard of care, and the intervention arm is only different in some trivial way. But this kind of trial might be used to establish a new product, with a new marketing approval and new patent exclusivity. The pharmaceutical company behind it will be motivated by this to increase marketing, launch a post-marketing study, and engage in other dissemination practices designed to increase the uptake of this new product into clinical practice. If successful, this will have lasting implications for health systems that may find themselves paying more for a new brand name drug and making healthcare

funding priority decisions that are influenced by its presence in the market. Thus, despite the relatively lower risk levels inherent in this study, the justificatory basis of the SVR remains.

Another push on the demandingness of the SVR can be made from the opposite direction. It might be suggested that the basic structure model goes too far: if long-lasting, non-voluntary impacts on the life chances of community members combined with the potential for erosion of background justice is sufficient to draw an institution under the umbrella of basic structure justice concerns, this may have implications for other pervasive institutions as well. For instance, we might think that social media has become so ubiquitous, its social influence so impactful, that it too would be captured under the rubric of “basic structure”.³¹ However, while this may be an implication of the view that I’ve laid out, this need not be a criticism of it. While the SVR may not be the appropriate test to levy against all institutions that have basic structure implications, we should not shy away from the idea that institutions that have such implications are relevant to justice, and that society therefore has a legitimate claim to moral consideration in their governance.

Conclusion

Much discussion in the research ethics literature is predicated, explicitly or implicitly, on the transactional model of stakeholder obligations. I have demonstrated why that model of the clinical research enterprise is insufficient to capture all of the morally relevant features that an adequate framework should address. In particular, I have showed how the implications of the research enterprise on the life chances of those governed by health systems, as well as the background conditions necessary for free and fair interactions, suggest that a better model for representing research stakeholder obligations is the basic structure model.

Once we view clinical research through the lens of the basic structure model, the importance of a restriction such as the social value requirement is immediately less puzzling. Where those working within the transactional model must find new and creative ways to explain why members of a community are somehow parties to a transaction between a private corporation and those whom that corporation chooses to compensate for their trouble, the basic structure model lays bare the standing that all have to claim a voice in biomedical research priorities. While the SVR gains support from many of the transactional arguments represented in the literature, its core justification is grounded in the deep and pervasive impacts that the research enterprise has on the life chances of every individual, not only those who participate in medical research.

Acknowledgments

The author would like to thank Derrick F. Gray, Alex J. London, audiences at the 2017 American Society for Bioethics & Humanities annual meeting and at the University of Minnesota Mankato, as well as two anonymous reviewers and the editorial staff at *Hastings Center Report* for their thoughtful comments on earlier versions of this paper.

¹ "The Nuremberg Code," in *Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No. 10. Nuremberg, October 1946-April 1949* (Washington, DC: U.S.G.P.O., 1949).

² The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (Washington, DC: Department of Health, Education, and Welfare, April 1979).

³ World Medical Association, *Declaration of Helsinki* (2013): Guideline 16.

⁴ Council for International Organizations of Medical Science (CIOMS), *International Ethical Guidelines for Health-Related Research Involving Humans* (2016): Guideline 1.

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- ⁵ E.J. Emanuel, D. Wendler, and C. Grady, "What Makes Clinical Research Ethical?" *Journal of the American Medical Association* 283, no. 20 (2000): 2701-2711.
- ⁶ Emanuel, Wendler, and Grady, "What Makes Clinical Research Ethical?"; D.J. Casarett, J.H.T. Karlawish, and J. Moreno, "A Taxonomy of Value in Clinical Research," *IRB: Ethics and Human Research* 24, no. 6 (2002): 1-6.; C. Grady, "Thinking Further About Value: Commentary on 'A Taxonomy of Value in Clinical Research'," *IRB: Ethics and Human Research* 24, no. 6 (2002): 7-8.
- ⁷ D.M. Wenner, "The Social Value of Knowledge and the Responsiveness Requirement for International Research," *Bioethics* 31, no. 2 (2017): 97-104.
- ⁸ A. Wertheimer, "The Social Value Requirement Reconsidered," *Bioethics* 29, no. 5 (2015): 301-308; D.B. Resnik, "Examining the Social Benefits Principle in Research with Human Participants," *Health Care Analysis* 26, no. 1 (2018): 66-80.
- ⁹ Wertheimer, "The Social Value Requirement," 302-303.
- ¹⁰ Wertheimer, "The Social Value Requirement," 302-303.
- ¹¹ A. Wertheimer, "Is Payment a Benefit?" *Bioethics* 27, no. 2 (2013): 105-116.
- ¹² D. Wendler and A. Rid, "In Defense of a Social Value Requirement for Clinical Research," *Bioethics* 31, no. 2 (2017): 77-86. For a similar argument about the role of social investment in research, see also A.J. London, J. Kimmelman, and M.E. Emborg, "Beyond Access Vs. Protection in Trials of Innovative Therapies," *Science* 328 (2010): 829-830.
- ¹³ A.J. London, "A Non-Paternalistic Model of Research Ethics and Oversight: Assessing the Benefits of Prospective Review," *Journal of Law, Medicine & Ethics* 40, no. 4 (2012): 930-944.
- ¹⁴ F.S. Holzer, "Defending the Social Value of Knowledge as a Safeguard for Public Trust," *Bioethics* 31, no. 7 (2017): 559-567.
- ¹⁵ Resnik, "Examining the Social Benefits Principle."
- ¹⁶ Wendler and Rid, "In Defense of a Social Value Requirement."
- ¹⁷ London, Kimmelman, and Emborg, "Beyond Access Vs. Protection."
- ¹⁸ CIOMS, *International Ethical Guidelines*, Guideline 1.
- ¹⁹ See, for example, A.D. Lyerly, M.O. Little, and R. Faden, "The Second Wave: Toward Responsible Inclusion of Pregnant Women in Research," *International Journal of Feminist Approaches to Bioethics* 1, no. 2 (2008): 5-22; C.B. Krubiner and R.R. Faden, "Pregnant Women Should Not Be Categorized as a 'Vulnerable Population' in Biomedical Research Studies: Ending a Vicious Cycle of 'Vulnerability'," *Journal of Medical Ethics* 43, no. 10 (2017): 664-665.
- ²⁰ See, for example, A.J. London, J. Kimmelman, and B. Carlisle, "Rethinking Research Ethics: The Case of Postmarketing Trials," *Science* 336 (2012): 544-545; A.J. London, "Justice in the Application of Science: Beyond Fair Benefits," *American Journal of Bioethics* 10, no. 6 (2010): 54-56.
- ²¹ See, for example, G.A. Cohen, "Where the Action Is: On the Site of Distributive Justice," *Philosophy & Public Affairs* 26, no. 1 (1997): 3-30.
- ²² J. Rawls, *A Theory of Justice* (Cambridge: Harvard University Press, 1971), 7.
- ²³ Rawls, *Theory of Justice*, 7.
- ²⁴ J. Rawls, *Political Liberalism* (New York: Columbia University Press, 1996), 265-269; J. Rawls, *Justice as Fairness: A Restatement* (Cambridge: Belknap Press, 2001), 52-55.
- ²⁵ Rawls, *Political Liberalism*, 269-271; Rawls, *Justice as Fairness*, 55-57.
- ²⁶ P. Trouiller et al., "Drug Development for Neglected Diseases: A Deficient Market and a Public-Health Policy Failure," *Lancet* 359 (2002): 2188-2194.
- ²⁷ J.D. Chambers et al., "Drugs Cleared through the FDA's Expedited Review Offer Greater Gains Than Drugs Approved By Conventional Process," *Health Affairs* 36, no. 8 (2017): 1408-1415.
- ²⁸ J.A. Evans, J. Shim, and J.P.A. Ioannidis, "Attention to Local Health Burden and the Global Disparity of Health Research," *PLoS ONE* 9, no. 4 (2014): e90147.
- ²⁹ D.M. Wenner, "The Social Value of Knowledge and International Clinical Research," *Developing World Bioethics* 15, no. 2 (2015): 76-84.
- ³⁰ Emanuel, Wendler, and Grady, "What Makes Clinical Research Ethical?"; E.J. Emanuel et al., "What Makes Clinical Research in Developing Countries Ethical? The Benchmarks of Ethical Research," *Journal of Infectious Diseases* 189 (2004): 930-937.
- ³¹ I'm grateful to Joseph Millum for pressing this example.