DOES THE LAW ON COMPENSATION FOR RESEARCH-RELATED INJURY IN THE UK, AUSTRALIA, AND NEW ZEALAND MEET ETHICAL REQUIREMENTS?

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ABSTRACT

Despite a consensus that society owes an ethical obligation to compensate for research-related injury, and that no-fault is the best ethical response, an assessment of the compensation arrangements in place in the UK, Australia and New Zealand shows that in general compensation arrangements fall below this ethical expectation. Most subjects rely on ex gratia payment or an unenforceable assurance of payment in the event of injury. It is also likely that, given significant deficiencies in participant information about compensation arrangements in place for trials recommended by the supervisory ethics agencies in each jurisdiction, subjects only find out about their financial exposure in the event of injury. Industry-drafted guidelines governing compensation in commercially sponsored trials do not protect subjects’ interests, but operate primarily to protect the interests of industry. The article considers potential solutions to the ethical deficiency of the compensation arrangements, and argues that the ethical corollary of the fact that society is the ultimate beneficiary of its members’ participation in clinical research, is that society as a whole should bear the cost of participant injuries, through establishment of a central no-fault compensation fund financed either by the state or those directly involved in biomedical research.

KEYWORDS: Clinical trials, Informed consent to compensation arrangement in research, Compensation for research-related injury, Ex gratia compensation

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INTRODUCTION

Nearly forty years ago the Pearson Commission said of volunteers in research:

We think it is wrong that a person who exposes himself to some medical risk in the interests of the community should have to rely on *ex gratia* compensation in the event of injury.¹

Yet that is precisely the position that most British, Australian and New Zealand subjects injured in clinical research, both publicly and commercially funded, remain in today. The information about compensation arrangements recommended by ethics oversight agencies to be given to subjects in each country is inadequate. As a result, it is likely that they only belatedly discover their financial exposure after injury.

While there are clinical trials on all kinds of medical treatments, procedures, and services, the focus of this article is on those on new medicines. In Section II of this essay, I describe the consensus among national commissions, as well as leading bioethicists, that society has a moral responsibility to compensate participants injured in clinical research. Because of the special difficulties for subjects in establishing the preconditions of negligence liability, which are even more acute for research-related injuries than for treatment injuries, there is general agreement also that no fault is the best ethical response. Section III comprises a comparative survey of the legal position relating to compensation for research-related injury in the UK, Australia, and New Zealand, and a critical assessment of the extent to which this ethical expectation is satisfied. Section IV catalogues additional deficiencies in the industry-drafted guidelines used in all three jurisdictions governing compensation in industry trials. In Section V, I assess the information recommended to be provided to potential participants in each jurisdiction about the compensation arrangement in place. In Section VI, three potential responses to the ethical inadequacy of the existing compensation arrangements are considered. The solution endorsed here is the establishment of a central no-fault compensation fund.

II. MORAL OBLIGATION TO COMPENSATE INJURED PARTICIPANTS ON A NO FAULT BASIS

In the last fifty years, there has been a stream of new and improved medicines and treatments which have increased life expectancies, improved quality of life, and reduced rates of morbidity. All have had to be tested for the first time on healthy volunteers in Phase I studies, followed by small Phase II trials on patient-volunteers, then larger Phase III ones. The greatest benefit is to future patients afflicted by diseases and injury through the availability of new, (generally) safe, and effective therapies. But the population as a whole benefits from advancements in scientific knowledge, even if the medicine turns out on balance not to be beneficial. Thus, society’s interests are advanced by people’s participation in clinical research.

This progress comes at a cost to a minority of subjects, who suffer research-related injury. There are notorious cases of deaths and catastrophic injuries: the French Bial drug trial disaster in 2016, which left one participant brain dead and five others

¹ Royal Commission on Civil Liability and Compensation for Person Injury (the Pearson Commission), vol 1 (Cmd 7054+1, 1978), 286.
critically ill; and the Northwick Park study in 2006, in which six healthy men participating in a Phase I trial of a novel monoclonal antibody made by a German manufacturer suffered multi-organ failure within 12 hours of ingestion. But harm that is never publicised is also caused to a small number of participants in routine clinical research. Though there is little recent data, research-related injury is claimed to be low in incidence, especially for major and catastrophic injuries. The risk in non-therapeutic research is said to be no greater than that experienced in everyday life, and that in therapeutic research, no greater than that in ordinary medical treatment itself.

Clinical research is fundamentally different from ordinary medical care. Ordinary medical treatment aims to benefit a specific patient. The doctor weighs the risks and potential benefits of an intervention, and recommends a personalised regimen only where the benefits outweigh the risks for that individual. In contrast, the sole goal of biomedical research is to produce generalizable knowledge that can be used to benefit future patients. Benefitting individual participants is never its goal. This is most apparent in non-therapeutic research, in which the participant is exposed to unknown hazards with no prospect of compensating benefit. But even where patient-volunteers suffer from the condition the drug is being developed to treat, the research is not designed to benefit them. Any benefit to individual participants is fortuitous and incidental. In addition, the methodologies of research, such as randomization, double-blinding, and placebo control, often subordinate an individual participant’s personal best interests and wishes to the dictates of the protocol.

There are two main opposing views about whether there exists an ethical requirement to compensate injured research subjects. The position that there is none proceeds from the principle of autonomy. It argues that providing subjects have been clearly and accurately informed of the risks of participation, and with full knowledge, have given a voluntary and informed consent to participate, the consent constitutes a waiver of a claim for compensation in the event of injury. This view has been strongly rebutted. It is pointed out that disclosure of the risks of the research is not equivalent to disclosure of the absence of a legal right to compensation for injury. And, in any event, the function of consent, while a necessary moral condition to ethically justified research, is only to authorise research involving interference with a subject’s person to proceed, rather than to shift the financial burden of risk from researcher to subject.

4 See Phillippe V Cardon and others, ‘Injuries to Research Subjects: A Survey of Investigators’ (1976) 295 NEJM 650, 653–54. Their 1976 US survey of 331 investigators conducting research on nearly 133,000 participants over three years is widely cited. It found that of 4,957 injuries, 3,926 were classified as trivial. Of the 93,000 participants in nontherapeutic research, 0.8% were reported injured; no-one died, one was permanently disabled, 37 were temporarily disabled, and 673 suffered trivial injuries. Of the 39,000 participants in therapeutic research, 10.8% reported injuries: 43 deaths, 13 permanent disabilities, 937 temporary disabilities, and 3,253 trivial injuries.
Thus, the widely held position since the 1960s has been that a subject’s fully informed consent to participate does not remove society’s moral obligation to compensate for research-related injury. James Childress appealed to the ethical principle of compensatory justice to justify a moral obligation on society to compensate injured research subjects. He identified three features giving rise to the obligation: (1) The injured party accepts or is compelled to accept a position of risk that s/he would not otherwise have encountered; (2) The general aim of the activity is to benefit society; and (3) Society, though its government or agencies, conducts, mandates, or sponsors the activity in question. Just as a soldier who undertakes risks and is injured in military operations in the service of society is due compensation, so too is compensation owed to injured research participants to fulfill a moral obligation arising because they have exposed themselves to risk for the benefit of the community in socially sponsored or mandated research. He included industry-sponsored research within the societal obligation because society requires drug testing for licensing purposes. Further, the moral obligation arises even though participation is voluntary, and whatever participants’ subjective motives for participating, as they still objectively assume a position of risk which inures to the benefit of society. While the paradigm case is nontherapeutic research, he argued that the possibility of the subject benefiting in therapeutic research does not cancel the obligation, because there is uncertainty about the best treatment or procedure and the subject still accepts a position of risk for society’s benefit.9

Since the benefits of research are reaped by the whole community, the argument favoured here is that the compensatory obligation should be assumed by society as a whole. But it is not essential that society itself compensate subjects. It could discharge its obligation by requiring that those who stand to benefit most directly from research (the research team, sponsors, institutions) do so. Reasons advanced for placing the primary responsibility on the research enterprise include that: it derives the most immediate, direct benefits from research; it can calculate, internalise, and pass on the costs of compensation; it is closest to and so can most efficiently compensate injured subjects; and its responsibility is consistent with recognised ethical principles of beneficence, and non-maleficence.10 The premise of compensatory justice is to restore injured subjects to the position they enjoyed before the injury. It follows that compensation would include: free medical care, acute and long-term; non-economic losses (pain and suffering); economic losses (lost income, out-of-pocket expenses); temporary and permanent disabilities; and death benefits in fatal cases.11

Other moral justifications include: intuition (compensating injured participants seems the right thing to do); reparative justice (focusing on the needs of the injured participant and compensating to repair the harm); non-maleficence and beneficence (minimising the risks of harm to subjects from conducting research and, since all risks cannot be eliminated, minimising the impact of harm from injuries); distributive justice (ensuring fairness in the distribution of the benefits and burdens of research, by shifting some of the benefits of research from those likely to derive benefits from it

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9 ibid, 26.
11 Childress (n 8), 26; ibid, 650.
(researchers, sponsors, future patients, society) to the few participants disproportionately and unfairly burdened by injury); utilitarian justifications (to encourage participation in research); economic justifications (to incentivise investigators and sponsors, who are best able to evaluate the risks to subjects, to consider carefully what research to conduct and to manage and minimise the associated risks, by requiring them to bear the financial risk of injuries); and to avert a loss of public trust in researchers, sponsors and clinical research likely to result from participants being left to bear the costs of their injuries alone.12 The Royal College of Physicians of London (RCP) claimed in 1990 that subjects themselves expect that, if injured in research, they will be compensated. In view of these moral justifications, it concluded not surprisingly that the expectation was ‘reasonable and, [it] believed, had public support’.13

There is also a broad consensus that no-fault compensation is the best ethical response to research-related injury. The poor job that tort law performs as a compensation mechanism is notorious, particularly in medical negligence. The process is expensive, adversarial, stressful, lengthy, antithetic to rehabilitation, and a ‘forensic lottery’, in that it tends to over-compensate a few ‘big winners’, while inadequately compensating many ‘losers’, most of whom never sue or cannot establish liability. Tort law is even worse at compensating injured research participants than injured patients. The key cause of action is negligence, but the chances of succeeding against investigators and sponsors are extremely limited, because of a subject’s difficulty in establishing its elements.

The most serious obstacle lies in proving fault by researchers or sponsors. Some risks in research are unpredictable and unforeseen, even if the research is carried out carefully. Discovering what the risks are and their extent is often the very purpose of undertaking the research in the first place. When injury occurs, it is more often because an unforeseeable risk occurred, rather than any negligence or deviation from the research protocol by researcher or sponsor. Participants are therefore likely to experience major difficulty in proving that harm was reasonably foreseeable. The chances of successful litigation are highest where there is non-compliance by the research team; yet it causes a minority of research-related injuries.14

The second key barrier is that proof of the causal link between a subject’s participation in the research and the injury is particularly difficult in clinical research, and often requires expert medical analysis. Patient-volunteers often encounter difficulty in therapeutic trials, in proving that their injury was attributable to the administration of the trial product or a clinical intervention required by the protocol, as opposed to progression of their underlying condition. Or it may only be possible to show that the research intervention increased the statistical chance of contracting a condition (such as cancer) in the future, rather than that it caused or materially contributed to the subject developing it. This is inadequate proof of legal causation in most jurisdictions.15

15 ibid, 28.
There is an alternative claim in the UK pursuant to the Consumer Protection Act 1987, which imposes strict liability on producers and suppliers of products for any damage, including personal injury or death, caused wholly or partly by a defect in the manufacture of the product. A product is defective if it does not provide the safety which persons generally are entitled to expect. Strict liability has not, however, significantly improved an injured subject’s prospects of obtaining compensation. The key reason is that the statute provides a ‘state of the art’ or ‘development risk’ defence for a manufacturer, who can show that:

the state of scientific and technical knowledge at the [time of supply] was not such that a producer of products of the same description as the product in question might be expected to have discovered the defect if it had existed in his products...16

Essentially, a manufacturer has a good defence if the defect was undiscoverable in the light of contemporary scientific knowledge. As indicated, unforeseeable risks are inevitable in experimental research, and fault is usually absent.17

Hence, as Pike says, the tort system is ‘uniquely difficult for injured research participants, even as compared with injured medical patients’ in ways that are difficult to overcome, resulting in substantial unfairness.18 Most injured research subjects will not sue, or will settle or lose at trial.19 Despite undertaking the risks of the research for no or uncertain individual benefit, tort almost always leaves injured participants to bear the full financial burden of their injuries alone, to which the beneficiaries of research are not required to contribute. Only no-fault compensation will adequately protect participants in respect of injuries for which negligence cannot be established. Thus, no fault compensation is the legal expression of society’s ethical obligation to compensate injured research subjects who accept the risks and suffer injury at society’s bidding and for its benefit.20 In addition, because of the absence of blame, no fault encourages trust between research team and subjects, and open disclosure by the former, which may assist them in developing systems for preventing future injuries.21

The ethical superiority of no fault is reflected in international ethical guidance,22 and by the fact that leading bioethicists, a line of blue-ribbon national advisory commissions in the USA since 1978, notably the Belmont Report,23 as well as the Pearson

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18 Pike (n 14), 26.
21 ibid, 483.
22 See for example, Council for International Organisations of Medical Sciences (CIOMS), International Ethical Guidelines for Health-related Research Involving Human Subjects (2016) Guideline 14 and Commentary.
23 For a summary of their findings, see Pike (n 14), 17–23.
Commission and other leading medical bodies in the UK, 24 have repeatedly recommended no fault compensation backed by appropriate insurance to protect injured subjects in clinical trials.

III. COMPENSATION SYSTEMS FOR RESEARCH-RELATED INJURY IN THE UK, AUSTRALIA, AND NEW ZEALAND

In this section, I examine the compensation systems in place in the UK, Australia, and New Zealand, and the extent to which they measure up to the ethical requirement of no-fault. All three jurisdictions have relied heavily on industry self-regulation via non-legislative guidelines monitored by ethics committees for regulating compensation for injury in commercially funded trials.

A. The United Kingdom

US commentators lament a subject’s lack of a legal right to no-fault compensation in federally funded research in that country, and that in general the only source of compensation is the negligence action. 25 They point approvingly to the requirement for sponsors to put in place insurance or indemnity in European countries, including the UK, and endorse a no-fault insurance/self-insurance requirement for the US. 26 Closer examination of the UK position, at least, suggests that the case for envy is overstated.

The European Directive 2001 imposed a common legal framework for the regulation of clinical trials involving medicinal products undertaken in member countries. It was transposed into UK domestic law by The Medicines for Human Use (Clinical Trials) Regulations 2004. After its implementation, the Directive was heavily criticised. 27 It was accordingly replaced in 2014 by the European Regulation on clinical trials on medicinal products for human use, which came into force directly in May 2016. 28 It was designed to further streamline trial review and approval processes, with the purpose of ensuring that the EU becomes a more attractive place in which to conduct clinical trials. 29

24 See the Pearson Commission (n 1), paras 1339–41; RCP, Research on Healthy Volunteers (1986), 11–13 and recommendations 24, 32; RCP (n 13), paras11.1–11.11; RCP, Guidelines on the Practice of Ethics Committees in Medical Research Involving Human Subjects (2nd ed, 1990), paras 16.10, 16.15.

25 The Common Rule applicable to federally funded research only entitles injured subjects to be informed whether or not care and compensation will be available and what it consists of, if the study entails more than minimal risk, see Basic HHS Policy for Protection of Human Research Subjects, s 46.116 (a)(6) [the Common Rule].


27 It was said to be responsible for a drop in the number of clinical trials being conducted in Europe, an increase in their costs, particularly insurance costs, and a slowing down of approval processes.


29 It brought within the scope of regulation a new category of a ‘clinical study’ of medicinal products, and introduced the concept of a ‘low intervention’ clinical trial, subject to less stringent rules, for example in respect of monitoring. It also exempted the latter from the obligation of mandatory insurance specifically for that trial, instead permitting sponsors and investigators to include them within a collective compensation
Like the Directive, the EU Regulation continues devolution to member states of the liability rule for research-related injury each chooses to adopt. It leaves the preconditions for a sponsor’s or investigator’s liability, including issues of causality and the level of damages, to be governed by national law. This was a second missed opportunity, after the Directive, to legislate for obligatory no-fault compensation for research-related injury in member states. And so there is diversity in liability rules across the EU. Germany, Belgium, and Spain, for example, are ethical exemplars, having no fault systems and compulsory insurance laws, requiring only a causal relationship between the trial and the injury. Similarly, Sweden, Finland, Norway, and Denmark have no-fault patient insurance schemes for medical injuries generally, which include research-related injury. At the other end of the spectrum, Polish legislation requires subjects to prove negligence on the part of sponsors or researchers before they are entitled to compensation.

In the UK, a sponsor’s or researcher’s liability is determined either by common law negligence or strict liability under the Consumer Protection Act 1987. The EU Regulation does, however, require that member states ensure that systems for compensation for any damage suffered by a subject are in place in the form of insurance, a guarantee, or a similar arrangement with equivalent purpose and which is appropriate to the nature and the extent of the risk. This is designed to ensure that a subject can successfully collect damages for any liability in accordance with members’ applicable laws. Ethics committees are required to check the arrangements in place as part of ethical review. The subject must be given information about the compensation system. There are separate compensation arrangements for non-commercial and commercial trials.

I. Publically funded trials in the UK

To recover compensation in publically funded research, an injured subject would first have to establish legal liability against a public-sector sponsor and/or investigator. In the minority of cases in which negligence liability arises, NHS bodies acting as sponsors or co-sponsors (such as NHS Trusts, the Medical Research Council (MRC), the Department of Health), and investigators and other staff involved in clinical trials in the course of their NHS employment are normally covered by the NHS Indemnity. But where harm occurs without negligence and no liability arises, such...
as where an unforeseeable side effect of the trial medicine occurs, the NHS Indemnity
does not apply.\textsuperscript{38} The \textit{Standard Operating Procedures for Research Ethics Committees}
state that in these circumstances:

\begin{quote}
[T]here are no guidelines on whether provision for no-fault compensation
should be in place. It is an ethical issue for the sponsor and the REC to consider
on a case by case basis, taking into account the potential risk . . . and whether the
sponsor is in a position, legally and financially, to make such an undertaking.\textsuperscript{39}
\end{quote}

But the UK Government forbids NHS bodies from offering advance compensation to
subjects or indemnities to NHS staff or from taking out commercial insurance for non-
negligent harm. Hence, NHS organisations sponsoring trials, such as the MRC when
acting as a sponsor, have no legal power to put in place in advance a no-fault compensa-
tion scheme for a clinical trial backed by an insurance policy, nor to advise its avail-
ability to subjects in an information sheet. They are, however, permitted to operate an
\textit{ex gratia} system: ‘In exceptional circumstances (and within the delegated limit of
£50,000) NHS bodies may consider whether an \textit{ex-gratia} payment could be offered.’\textsuperscript{40}

In adhering to this position, the Government has rejected the long-held view of
the RCP, which said in 1990 that reliance on \textit{ex gratia} payments no longer reflected
reasonable public expectations:

\begin{quote}
Bodies that sponsor research, including both publically funded . . . and the phar-
maceutical industry, should now so arrange their affairs as to implement the
principle that injury due to participation in research sponsored by them or con-
ducted by their staff . . . shall be compensated by a simple, informal and expedi-
tious procedure. In the event of any significant injury the patient must be enti-
tled to receive compensation regardless of whether there may or may not have
been negligence or legal liability on any other basis.\textsuperscript{41}
\end{quote}

The RCP considers the compensation arrangements in public trials ‘much less satis-
factory’ than those applicable to industry trials, of which it is also critical.\textsuperscript{42} There is
no special arrangement for Phase 1 studies, no published commitment to pay no-fault
compensation, no guidelines nor publically stated criteria for \textit{ex gratia} payments, and
no ability to put in place in advance a no-fault arrangement, indemnity, or insurance

\textsuperscript{38} Note also that the NHS Indemnity does not apply in cases of strict liability under the Consumer Protection
Act 1987 either, unless it can be shown that a health professional either knew or should reasonably have
known that the drug was faulty but continued to use it, see \textit{NHS Indemnity} ibid, Questions & Answers,
question 14.
10.
40 See NHS Indemnity (n 37) question 16.
41 See RCP (The Royal College of Physicians of London, 1990) (n 13), paras 11.7–11.9. See also, RCP (The
Committees in Medical Research Involving Human Participants} (4\textsuperscript{th} ed, The Royal College of Physicians,
2007), paras 4.15, 4.22, and 4.23. See also R Gillon, ‘No Fault Compensation for Victims of non-
therapeutic research — should the Government Continue to be exempt?’ (1992) 18 J Med Ethics 59.
42 RCP 2007 ibid, para 4.22.
cover. And, as we will see, it is not recommended that subjects be informed of the availability of *ex gratia* payments. Accordingly, subjects, even those in Phase I studies, must either establish legal liability, or rely on an *ex gratia* payment from the NHS sponsor or the NHS authority employing the researcher.\(^{43}\) Since the public sector does not have its own ethical house in order, it is perhaps unsurprising that the UK Government has not required legally enforceable no-fault compensation of industry.

2. Commercially sponsored trials in the UK

In each jurisdiction the pharmaceutical industry has been permitted by governments to regulate the availability of compensation in commercially sponsored trials through industry-drafted guidelines. From the start of this approach, the Association of the British Pharmaceutical Industry (ABPI) has always taken a different approach to compensation for healthy volunteers than for patient-volunteers.\(^{44}\) Its first *Phase I Guidelines* recommended that sponsors put in place a legally enforceable commitment to pay no fault compensation to injured subjects, whereas any obligation to compensate patient-volunteers in Phase II and III trials has always been ‘without legal commitment’. The justification for the different treatment is that participants in Phase I trials are considered to be a special group. They are more vulnerable because they expose themselves to an unknown (usually greater) risk of harm with no possibility of personal benefit from participation to compensate for the risks being undertaken. The ABPI has accepted that legally guaranteed no-fault compensation is ethically appropriate.\(^{45}\) Also, without a legally binding commitment to compensate for injury, recruitment would be very difficult. The ABPI’s first *Guidelines* in 1970 relating to staff volunteers recommended a separate, legally enforceable contract entered into with each to provide no fault compensation. After a critical RCP report following the deaths in 1985 of two medical students in Phase I trials, its 1988 *Guidelines* recommended its members extend the same contractual arrangement to all healthy volunteers.\(^{46}\)

The current *Guidelines* for Phase I trials now ‘require’ (rather than ‘recommend’, as formerly) that member companies ensure that arrangements are put in place that create a legally binding obligation to pay ‘appropriate’ no-fault compensation on proof of causation, without waiver of a volunteer’s right to pursue a legal claim in negligence or strict liability.\(^{47}\) The legal obligation is put in place through the terms of the consent form and subject information sheet, which are drafted as a binding contract between sponsor and subject. Compensation is not fully no-fault, since the amount

\(^{43}\) See MRC, *Statement on Indemnity* (2008), paras 3 and 4. Note, other non-NHS, public sector funding bodies, such as universities and medical research charities, are able to make compensation arrangements and put in place insurance to compensate participants for non-negligent harm in advance of a trial.

\(^{44}\) The ABPI is the UK organisation which represents the interests of the pharmaceutical industry. In 2009, approx. 75 percent of studies requiring clinical trial authorisations were sponsored by industry, see The Academy of Medical Sciences, *A New Pathway for the Regulation & Governance of Research* (2011), 43.

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can be reduced by a subject’s contributory fault.48 ‘Any significant deterioration in health or wellbeing’ is compensatable, whereas under the ABPI Guidelines for Phase II to IV studies only ‘more serious injuries of an enduring and disabling character’ are (voluntarily) compensatable.49 As long ago as 1986, the RCP recommended proof of causation based on a reasonable inference, rather than balance of probabilities, where injury occurs during or shortly after the study, with the benefit of doubt going to the volunteer in marginal cases, but the ABPI has never taken up such a claimant-friendly approach.50 Where the injury is due to a third party’s negligence, such as that of a contract research organisation or an investigator, the Guidelines say that the contract should identify which party undertakes to pay compensation. Where that is the sponsor, it should accept an unqualified obligation to pay compensation to the subject quickly, and resolve separately with the third party which party will finally bear the cost. The amount of compensation is to be calculated by reference to damages awards for similar injuries in an English court where liability is admitted. A simple arbitration clause to resolve disputes relating to implementation of the compensation provisions is recommended.51

Under pressure from ethics committees for assurances that subjects harmed in Phase II and III studies would also be appropriately compensated, the ABPI issued its first guidelines for them in 1983. These recommended that member companies ‘favourably consider’ though ‘without legal commitment’ the provision of compensation for injury, including death, suffered by patient-volunteers without the requirement for negligence to be proved.52 An influential Commentary accompanying announcement of the Guidelines advised that a legally enforceable commitment to individual subjects via a contract with each would be ‘cumbersome’, ‘inadvisable and unworkable’, and that injured subjects would not ultimately benefit, while at the same time inexplicably asserting that ‘[f]or healthy volunteers a separate legal contract with each healthy volunteer is feasible, and the draft contract recommended in 1970 ... admirable’. The authors said further that, while the ‘favourably consider’ and ‘without legal commitment’ wording ‘might be thought at first sight to offer nothing’, this deliberate choice of words ‘clearly denote[d] an intention that compensation should be provided.’ While that may have been so, a participant could not enforce implementation of any such intention. The commentators cited their experience that major companies did in reality honour the obligation to pay, even though legally unenforceable, and claimed that the Guidelines reflected ‘acceptance of the pharmaceutical industry as a whole of this attitude’.53

A second RCP report, Research Involving Patients in 1990, concluded that ex gratia payment of compensation in both publically funded and commercially funded research was no longer satisfactory. Patients were volunteers in research also and

48 ABPI (n 45), cl 4(ii).
49 Ibid, cl 4(i); ABPI, Clinical Trial Compensation Guidelines: Phase II, III & IV (2014), cls.1.1 and 1.4. Hereinafter “the ABPI Phase II-IV Guidelines”.
50 RCP 1986 (n 24), 12 & recommendation 33.
51 ABPI (n 45), cl 4(ii) & (iii).
52 For the first Guidelines, see A Diamond and D Laurence, ‘Compensation and drug trials’ (1983) 287 BMJ 675, 676–77. The Guidelines were revised in 1991.
deserved the same consideration as healthy volunteers. The ABPI Guidelines for patient-volunteers needed revision to provide a legal commitment to compensate injured patient-volunteers also.\textsuperscript{54} The ABPI has never, however, accepted this recommendation, and payment of no-fault compensation for injuries in industry trials, except for Phase I studies, has remained voluntary to this day.

Thus, the current ABPI 2014 Guidelines for Phase II–IV trials provide for a qualified form of no-fault compensation: ‘compensation should be paid regardless of whether the patient is able to prove the company has been negligent in relation to research and development of the medicinal product under trial’, or that the product is defective and the manufacturer is subject to strict liability in respect of injuries caused by the product.\textsuperscript{55} But the sponsor’s obligation to pay compensation is legally unenforceable by the injured participant. The Guidelines are merely a recommendation by the ABPI to its member companies to pay no-fault compensation. The Preamble states:

\begin{quote}
The Association of the British Pharmaceutical industry \ldots\textit{ recommends} that a member company sponsoring a clinical trial at Phase II, III, or IV should provide without legal commitment a written assurance to the investigator — and through him to the relevant research ethics committee — that the following guidelines will be adhered to in the event of injury caused to a patient that is attributable to participation in the trial in question.\textsuperscript{56}
\end{quote}

Note that the sponsor’s assurance is made, not to potential participants, but to the investigator and through him/her to the ethics committee, presumably so as to facilitate a favourable opinion. The wording ‘compensation should be paid’, rather than that the sponsor ‘must’ or ‘will’ pay, emphasises moral rather than legal responsibility. Clause 1.1 states:

\begin{quote}
Notwithstanding the absence of legal commitment, \ldots\textit{ the sponsoring company should pay} compensation to patient-volunteers suffering bodily injury (including death) in accordance with these Guidelines. [Emphasis added]
\end{quote}

Not all sponsoring companies are members of ABPI. It cannot require that its members, let alone non-member companies, adhere to the Guidelines even if they agree in information sheets to do so. Where the sponsor is not an ABPI member and has not agreed to adhere to the Guidelines, an \textit{ex gratia} payment may be the only way for an injured subject to receive any compensation, in the absence of proof of negligence.

Thus, in the UK the availability of compensation in all commercial trials, except Phase I, depends either on proof of liability, an unenforceable assurance, or \textit{ex gratia} payment. Only healthy and patient-volunteers with no prospect of benefit in Phase I trials have a legal entitlement to no fault compensation.

\textsuperscript{54} RCP 1990 (n 13), paras 11.7–11.9.
\textsuperscript{55} ABPI (n 49), cl 1.7.
\textsuperscript{56} ibid, Preamble [emphasis added].
B. Australia and New Zealand

1. Publically funded trials in Australia and New Zealand

Australian clinical trials are regulated by the Therapeutic Goods Administration (TGA) and subject to certain ethical standards set by the National Health and Medical Research Council (NHMRC). There are two Australian clinical trial notification schemes (CTN and CTX) intended to encourage clinical trials and enable participants to access unregistered treatments in the context of clinical trials. The difference is that under the CTN scheme an ethics committee alone evaluates the safety and efficacy of the medicine and the scientific and ethical validity of the trial, whereas under the CTX scheme both an ethics committee and the TGA do so. If the assigned TGA delegate raises an objection about the product, the trial may not proceed until the sponsor has satisfied the delegate as to the objection. The ethics committee in each host institution or organisation at which the trial will be conducted is responsible for assessing the application for compliance with the National Statement on Ethical Conduct in Human Research, which is a comprehensive national statement on standards for conducting ethical research on humans. The TGA has also issued a Note for Guidance on Good Clinical Practice (GCP), which also provides benchmark standards of conduct for clinical trials. Clinical trials must comply with both in order to receive a favourable opinion from an ethics committee.

Like the EU Regulation, the National Statement requires that all clinical trials have appropriate compensation, insurance and indemnity arrangements. The responsibility for these is placed on the sponsor, although it is an institutional responsibility to ensure that sponsors have made necessary and appropriate arrangements. The GCP also places the responsibility for compensation, insurance, and indemnifying the investigator and institution for any liability on the sponsor ‘in accordance with the applicable regulatory requirement(s)’. In addition, the institution must itself have its own compensation arrangement for negligently inflicted harm in research.

58 In Australia, institutions and organisations that conduct human research are responsible for establishing, resourcing and maintaining processes for ethical review, including establishing ethics committees. Ethics committees are primarily based in public and private hospitals, health services, universities, government departments, and not-for-profit organisations. Although they ‘belong’ to institutions, they are accountable also to the NHMRC.
59 NHMRC, National Statement on Ethical Conduct in Human Research 2007 (updated 2015). In multi-centre trials, the researcher and sponsor have to comply with the requirements of each separate institutional ethics committee, see K Cregan, ‘Regulating Ethics in Australian Healthcare Research’ (2012) 21 Cam Q of Healthcare Ethics 384. The NHMRC has developed a national approach to single ethics review of multi-centre research, see <https://www.nhmrc.gov.au/health-ethics/national-approach-single-ethical-review-multi-centre-research> accessed 12 April 2017.
60 See TGA, Note for Guidance on Good Clinical Practice (CPMP/ICH-135/95), paras 5.8.1–5.8.3.
61 See the National Statement (n 59), s 3.3.24.
62 See TGA (n 60), para 5.8.
63 ibid, s 3.3.25.
Neither the TGA nor the National Statement prescribe the ‘relevant regulatory requirement(s)’, which are a matter for each State or Territory to determine. And so, the design of the compensation scheme and the preconditions for liability, fault-based or no-fault, are a matter for each State and Territory. A State’s law or policy could in theory require a public sector sponsor to put in place no-fault compensation, and make the necessary insurance and indemnity arrangements to support liability on that basis, but most publically funded research operates on a fault-based system.

For research conducted by and in publicly funded research organisations, such as public teaching hospitals, the indemnity or insurance cover for its respective public health services is usually established pursuant to a statute and generally implemented and managed through a State government or government agency, such as a managed fund. These arrangements provide protection to State public health services against liabilities they may incur in connection with their ordinary activities in that jurisdiction. Clinical trials are treated as an ordinary class of activity undertaken as part of public health services, so that a service will be insured or indemnified against any liability incurred in the course of a trial. Cover extends to researchers who are employees of the service. The indemnity and insurance cover provided under State arrangements is negligence liability coverage, not no-fault cover. Thus, in order to be compensated, an injured subject would first have to prove negligence liability against the public health service. The insurance provider or indemnity would then indemnify the public health service or its employee for its liability to the subject. States also impose indemnity and insurance requirements on third parties that participate in trials conducted in the public health sector, such as a sponsor or collaborator. The most common example is the requirement that commercial sponsors provide legal indemnities, supported by insurance, to public sector entities when conducting a trial at a public institution, such as on patients in a public hospital. The public health service would be indemnified, but only for loss resulting from fault liability.

Accordingly, clinical trials conducted exclusively by public sector bodies do not typically put in place no fault compensation arrangements, nor do they provide insurance or indemnity coverage to support no-fault liability. Compensation is dependent on proof of liability, usually in negligence.

In New Zealand, injuries due to participation in publically funded trials are covered by the no-fault accident compensation (ACC) regime. This is a unique scheme, being a state-funded, no-fault scheme which extends to all accidental injury, not just to research-related injury or injury caused by medical treatment. From the injured participants’ perspective, access to compensation under the scheme is overwhelmingly superior to that pursuant to industry guidelines. The key advantage is of course that if they satisfy the statutory criteria, claimants are legally entitled to cover and the compensation and rehabilitation benefits specified in the Accident Compensation Act 2001. Entitlement depends entirely on the terms of the statute, not the discretion of the

64 Because the Commonwealth has limited direct power to legislate in relation to health, the ‘applicable’ regulatory requirements are those imposed by the law or policy of the state or territory.
66 See generally, Accident Compensation Act 2001, ss 67, 68, and 69, s 165 and the First Schedule.
funder. Because these must be interpreted by the Accident Compensation Corporation (ACC), the state agency administering the scheme, in the first instance and are then susceptible to appeal, the statutory criteria for cover are precisely defined, whereas vague language is able to be used to create the sponsor’s discretionary obligations under the Medicines NZ Guidelines.

The current Act provides cover for ‘treatment injury’ for personal injury suffered by a person as a result of treatment given as part of a clinical trial where an ethics committee approved the trial, and ‘was satisfied that the trial was not to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled’.67 If the ethics committee determines that the principal beneficiary of the trial is the manufacturer or distributor of the product, an injured participant has no ACC cover. Criteria have been developed to assist the ethics committee to make this determination, the key one being whether the sponsoring company is providing funding or materials for the proposed research.68 Cover for ‘treatment injury’ is no-fault; it is not necessary to prove negligence by a health professional or organisation.69 There is no exclusion for less serious injuries.

Proof of the causal link between treatment given in the trial and personal injury must still be established for cover purposes.70 It is the main challenge for claimants and can be responsible for delays in determining a claim. But the issue is susceptible to appeal, and there is claimant-friendly judicial interpretation of the causation requirement under the Act in recognition of the difficulties of proof for claimants.71 The main exclusion from cover is personal injury that is ‘a necessary part, or ordinary consequence, of the treatment’.72 Its rationale is that it is reasonable that the claimant should bear the financial risk of injuries which are an expected consequence of the treatment process. ‘Necessary’ injuries in treatment, such as an incision in the course of surgery, are relatively easy to identify, but the exclusion of ‘ordinary consequences of the treatment’, requiring an individualised determination for each patient and each intervention, does admittedly result in uncertainty. But a subject could reasonably expect to be informed beforehand about a risk inherent in a trial product considered by the research team to be likely enough to happen to be described as ‘an ordinary consequence’ of the drug. If not, the claimant may well be covered in any event under the alternative ground of injury caused by failure to obtain informed consent.73

In industry trials each country’s Guidelines exclude compensation for injury caused by other licensed products than the trial product, such as the standard drug given for comparison purposes.74 By contrast, ACC covers injuries resulting from

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67 Accident Compensation Act 2001, s 32(6).
69 Accident Compensation Act 2001, s 32(1)(a) and (b).
70 Reinforced by the exclusion of personal injury that is wholly or substantially caused by a person’s underlying health condition, see Accident Compensation Act 2001, s 32(2)(a).
71 See Accident Compensation Corporation v Ambros [2008] 1 NZLR 340 (CA) (courts can draw an inference of causation in the presence of some evidence of a causal link, despite that evidence not rising to the balance of probabilities).
72 See Accident Compensation Act 2001, s 32(1)(c).
73 ibid, s 33(1)(e).
74 See for example ABPI (n 49), cl 3.2.
the standard treatment in both public and industry trials, provided the statutory criteria for ‘treatment injury’ are satisfied. Thus, subjects injured in an industry-sponsored clinical trial randomly allocated to the standard treatment arm are comparatively better off than those injured in the same trial by the trial product, by virtue of being covered by ACC. This situation illustrates strikingly the arbitrariness in practice of having two separate compensation arrangements. Subjects would have been unaware beforehand to which treatment arm, standard, or trial, they were randomised.

Because compensation extends to non-negligently as well as negligently caused injuries, ACC compensation was never intended to approximate damages awards. Accordingly, the scheme does not provide full compensation as would be required by compensatory justice. Benefits are relatively modest and there are some gaps. For example, a lump sum for pain and suffering and loss of amenities was abolished in 1992, at a time when government perceived the scheme to be financially unsustainable and was intent on reducing its overall costs. But a significant advantage is that entitlements and their criteria are fixed and clearly stated in the statute, rather than being dependent on the exercise of an impenetrable discretion. The principal entitlement is weekly compensation, fixed at 80 per cent of loss of earnings at the time of injury for the whole period of incapacity. It includes limited compensation for loss of potential earning capacity. ACC is liable to pay for rehabilitation costs, which can amount to significant sums. These comprise a contribution to treatment costs, social rehabilitation, and vocational rehabilitation to assist return to employment. There is a modest lump-sum entitlement for permanent physical injury. There are funeral and survivor’s grants, and significantly, a percentage of the deceased’s weekly compensation for the spouse or partner (60%), children and other dependents (20%), where the deceased was an earner.

The statutory process for deciding claims and settling disputes is also vastly superior, especially in terms of fairness and independence. ACC is not commercially motivated by profit, and has statutory duties to decide claims on reasonable grounds, in a timely manner, and in accordance with the statutory criteria. It is not supposed to take an adversarial stance to claims, but must assist claimants to establish cover and access entitlements. Time limits within which it must decide claims are specified.

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76 The ACC scheme is particularly disadvantageous for non-earners, such those on benefits and unpaid caregivers.
77 Accident Compensation Act 2001, First Schedule, cl 47.
78 These can be particularly significant, and include disability aids and equipment (such as prostheses and wheelchairs), attendant care, home help, educational support, home modifications, transport costs, which can include modifying or purchasing a vehicle.
79 The maximum lump sum for 100% whole-person impairment was set in regulations at NZ$100,000 but is CPI indexed. Lesser percentages of whole-person impairment are equated to fixed sums on a regressive basis. See the Injury Prevention, Rehabilitation and Compensation (Lump Sum and Independence Allowance) Regulations, 2002 (SR 2002/22).
80 Accident Compensation Act 2001, First Schedule, cls 66, 70, 71.
81 For the balance between its social and financial objectives, see Accident Compensation Act 2001, s 262(3).
82 See Accident Compensation Act 2001, s 54.
83 See ibid, s 50.
ACC’s decisions are amenable to challenge by the parties, first by administrative review by an independent reviewer, followed by three levels of appeal to the courts. A differently designed no-fault scheme could specify different criteria for coverage and compensation could be more or less generous, depending on the extent of funding. ACC does, however, provide an insight into how a statutory no-fault compensation scheme established as an administrative fund operating outside the tort system might look.

2. Commercially sponsored trials in Australia and New Zealand

In both countries, the compensation arrangements in commercial trials are based on industry guidelines adopted from the ABPI’s Phase II–IV Guidelines. A local version of the ABPI’s Guidelines was adopted in Australia in 1994 because of an increasing trend for ethics committees to request that commercial sponsors abide by the ABPI Guidelines. The current version was issued in 2004. They were introduced in New Zealand in 1993 after government passed a new Act governing the scheme. One change was to remove ACC cover and access to compensation for personal injury resulting from participation in a commercially sponsored trial, although, as described, participants in publically funded trials continued to have ACC cover. As well as reducing cost, government’s reasoning was that, since industry would enjoy the profits from the sale of registered medicines trialled on New Zealanders, it rather than levy payers should meet the costs of compensation for injuries in its trials. There was also a concern that if industry trials were covered by the ACC scheme, New Zealand might be targeted by industry seeking to conduct questionable trials, which would then leave New Zealanders to bear the cost of injuries. Also, if required to bear the true costs of compensation, indemnity and insurance, as happened elsewhere, companies might be incentivised to increase safety in their trials. Thus, by agreeing to participate in a pharmaceutically sponsored trial, a subject surrenders ACC cover and access to statutory no-fault compensation if injured, and must instead look to researchers and sponsors for compensation. New Zealand’s lead ethics, standard-setting and ministerial advisory body in the sector, the National Ethics Advisory Committee (NEAC), has twice called on government, so far without success, to repeal or at least review the exclusion of injuries in industry trials from ACC cover. Its case is, it is submitted, ethically convincing. The unequal treatment of injured subjects in industry trials compared to those in publically sponsored trials in New Zealand is inequitable and discriminatory. Once injured, the source of funding for the trial in which they participated, commercial or otherwise, is immaterial to subjects.

84 A right of general appeal to the District Court, and two levels of appeal with leave on questions of law thereafter.
85 The APMA Guidelines 1994 were revised in 1996, and last updated in 2004, see Medicines Australia, Guidelines for Compensation for Injury resulting from Participation in a Company-sponsored Clinical Trial (2004). Hereinafter, the Medicines Australia Guidelines.
86 See NEAC, NEAC Analysis — Clinical trials (14 September 2010), para 47.
87 ACC and Ministry of Business, Innovation and Employment, Clinical trials and ACC cover — advice provided to Minister for ACC’s office, undated, 2.
88 NEAC (n 86), para 67(b); NEAC, Advice to Associate Minister of Health on Compensation for Treatment Injury in Clinical Trials Report No 20141482 (21 November 2014), para iv.
As a result of the removal of ACC cover, participants in industry trials were without financial protection apart from the tort action. Government, with the assistance of the Researched Medicines Industry (RMI), put in place industry-drafted Guidelines adopted almost word-for-word from the ABPI’s 1991 Guidelines then in use in the UK. Today Australia’s and New Zealand’s Guidelines are almost identical to the current ABPI Guidelines for Phase II–IV trials. Their key feature is that a sponsor’s obligation to pay no-fault compensation arises in ‘the absence of legal commitment’. Sponsors will purchase no-fault clinical trials insurance from a commercial insurer, either a blanket policy or on a trial-by-trial basis. One major difference, however, to the ABPI Guidelines is that the Australasian versions apply also to injuries in Phase I studies, whereas, as described, there are separate, legally enforceable ABPI Guidelines for Phase I studies in the UK. Thus, an Australasian sponsor’s obligation to pay no-fault compensation to participants injured in the riskier Phase I trials today is also without legal commitment for unexplained reasons, in stark contrast to the fact that the ABPI has considered it ‘ethically appropriate’ for sponsors to provide legally enforceable no fault compensation to these participants since 1970.

Do commercial sponsors pay out to injured participants if they have agreed in information sheets to provide compensation ‘in line with industry guidelines’, despite the ‘without commitment’ wording? Industry associations have on occasion assured the medical profession and ethics committees (though not participants) that its members would in reality pay out. It is open to question, however, whether this confidence is justified. As companies guard the fact and details of any settlements under the Guidelines as confidential and commercially sensitive, ethics committees may only learn of compensation payments by chance. Even if they do, they are not involved in the claims process and so, in the absence of transparent information from sponsors, ethics committees cannot reliably monitor the extent to which companies consistently pay claims under the Guidelines and their amounts.

Perhaps this confidence rests partly on the fact that companies have reputational interests and will want to avoid adverse publicity for the product, which are sufficient to incentivise them to make confidential settlements with injured participants, making legally mandated compensation non-essential. But it is open to question whether these interests are sufficiently pressing to override a company’s reluctance to pay out when not legally obliged to. As Stephen Guest, a legal member of a UK ethics committee, observed twenty years ago, drug injuries can be very expensive to compensate,
and ‘it is an unsatisfactory position for the injured subject that the research sponsor be faced with balancing cost against breaching a legally non-enforceable albeit moral undertaking. … [T]he research sponsor, or its overseas controlling company, may well decide that the costs are simply not worth it.’ If companies decide to treat industry guidelines as de facto binding, what would be lost by making them legally so? Perhaps part of the explanation lies in the fact that, even if a company accepts the need to make some payment in a particular case, once the claimant discovers that any payment is legally unenforceable, the negotiating power shifts dramatically in favour of the company (or its insurer). A claimant would then surely have to be more prepared to concede on other issues, such as the amount of compensation.

There is some New Zealand evidence of sponsor reluctance to pay compensation under the Guidelines. In 2012, two participants suffered serious injuries in separate commercially sponsored Phase III clinical trials, both trials having been approved by the Multi-Centre Ethics Committee. The Participant Information Sheets for each advised participants that the sponsor would pay medical expenses (the Insulin variant trial) or compensation (the CRYSTAL trial) in accordance with the Guidelines. The sponsor in the CRYSTAL trial initially maintained that the subject’s injuries were not caused by the investigational drug. Approximately three years later, in 2015, it finally reached a confidential settlement of his claim, after he had suffered significant loss of income in the meantime and had been forced to appoint a high-profile lawyer to represent him. A major barrier to settling his claim was that the sponsor’s insurance company took over management of the claim, and took a strict commercial approach to resolving it. At the date of writing the injured subject in the Insulin Variant trial has not received any compensation for his injury, despite also obtaining legal representation and ministerial pressure being applied on the sponsor to agree a date for mediation and to reach a settlement of the claim. After learning of these two cases, NEAC warned government ministers that these cases suggested that some companies conducting trials in New Zealand may be ‘failing to comply with [NEAC’s] and MNZ’s guidance to provide compensation cover for study participants to at least ACC equivalent standard, and to do so in an expeditious manner’. It warned

97 The first involved a man who suffered injury in a multi-country, Phase III, double-blind, randomised controlled trial of patients with type-2 diabetes who had never before taken insulin, comparing a new insulin variant medicine with an existing insulin treatment, see MEC Ref 11/1/092, Multi-region Ethics Committee Minutes 15 November 2011, 10. Hereinafter ‘the Insulin Variant trial’. The second involved a man, who had agreed to participate in a Phase III, randomised, double-blind, placebo-controlled, combination study of a gout medicine, and who suffered atrial fibrillation days after taking the trial medicine, see MEC Ref 12/02/013, Multi-region Ethics Committee Minutes, 21 February 2012, 6. Hereinafter the CRYSTAL trial.
98 Participant Information Sheets and Consent Forms for the Insulin Variant trial, 7 and CRYSTAL trial, 14 (on file with the author).
99 NEAC (n 88), para 13.
100 The sponsor argues that the investigational product did not cause the subject’s injury.
101 Letter dated 1 October 2015 Minister for ACC to [name withheld under s 9(2)(a) of Official Information Act 1982]; copied to HDEC chairs, MNZ, and Centre for Clinical Research, Middlemore Hospital.
that ‘if the public became aware of the difficulties faced by these participants, it could affect future participation in and conduct of clinical trials in New Zealand’.102

Thus, in each jurisdiction the law falls short of the ethical benchmark of no-fault compensation for research-related injury. A subject’s only certain means of obtaining compensation for injury is by establishing legal liability, with the attendant difficulties, cost, delay, and poor chances of success. There are two exceptions where the law does meet the ethical standard: first, in publically sponsored trials in New Zealand, and second, in commercially funded Phase I studies in UK. Otherwise a subject is reliant on an unenforceable assurance or *ex gratia* payment following non-negligent injury.

**IV. DEFICIENCIES IN INDUSTRY GUIDELINES**

In addition to their legal unenforceability, there are other serious deficiencies with the industry *Guidelines* for Phase II and III trials in each country that leave participants financially exposed.103 Firstly, the ‘obligation’ to pay compensation is not truly no-fault, being limited to negligence by the company only. No or reduced compensation can be paid for injury resulting from: wrongdoing by third parties, such as the investigator; significant departures from the agreed protocol; or the contributory negligence of the subject.104 Excluding injury arising from a significant departure from the protocol is especially harsh, since most subjects will never see nor agree to it, and will be unaware of and powerless over others’ departures from it.105 In the event of third party wrongdoing, the subject is expected to turn to it for compensation, which will only be forthcoming if its causative negligence can be established and it has funds to satisfy any award.106 Secondly, the clause defining the nature of the injury required for compensation is vague (‘only for more serious injury of an enduring and disabling character’) and excludes ‘temporary pain and discomfort or less serious or curable complaints’.107 The exclusion of curable complaints is highly problematic, since ultimately curable injuries can nevertheless be serious and prevent working for lengthy periods.

The clause relating to assessment of compensation is also vaguely drafted.108 Originally it gave no indication of appropriate sums. In 1991, the ABPI added the provision from its *Phase I Guidelines* that the amount of compensation should be consistent with the quantum of damages commonly awarded for similar injuries by an English Court in cases where legal liability is admitted.109 In 2009, in new ethical guidance for intervention studies, NEAC set the standard of ACC-equivalent

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102 NEAC (n 88), paras ii and 16.
103 The text draws on the description of these in N Peart and A Moore, ‘Compensation for Injuries Suffered by Participants in Commercially Sponsored Trials in New Zealand’ (1997) 5 Med LR 1. The text has been updated to refer only to defects that persist in the current *Guidelines* in all three countries.
104 See for example, ABPI (n 49), cl 3.4. References are to the APBI *Guidelines*, as the Medicines Australia and MNZ *Guidelines* are to the same effect, unless otherwise indicated.
105 Peart and Moore (n 103), 10.
106 Investigators are required to demonstrate, and ethics committees to check, that the investigator has professional indemnity insurance.
107 ABPI (n 49), cl 1.4.
108 ‘The amount of compensation paid should be appropriate to the nature, severity and persistence of the injury’, see ABPI ibid, cl 4.1.
compensation in commercially sponsored trials, and the MNZ Guidelines were amended to reflect this. No such addition has ever been made to the Medicines Australia Guidelines, so that its patient-volunteers are significantly disadvantaged by the absence of any guideline for quantum.

In 1997, Peart and Moore reported that: ‘most [New Zealand] companies will not compensate for loss of earnings or any other non-medical expenses, let alone for loss of earning capacity or for dependants. And some even limit compensation purely to medical expenses’ and then only in relation to physical, and not mental injuries. Though NEAC and the MNZ Guidelines have since set the benchmark of ACC-equivalent compensation, apparently little has changed. It seems clear that the commitment to pay ACC-equivalent compensation, albeit morally binding only, is often not honoured by companies. NEAC reported in 2010 and again in 2014 that sponsors were proving reluctant to meet this expectation. Some ethics committees have tried to pressure companies to honour this threshold, by insisting that ACC entitlements be explicitly itemised in information sheets, and by requiring inconsistent limitations, such as that a sponsor would not pay for lost wages, to be struck out. But, so long as researchers and sponsors are able to state in information sheets that the company agrees to provide compensation ‘in line with industry guidelines’, such commitments might add to moral pressure on sponsors to pay ACC-equivalent compensation, but they cannot make the obligation legally enforceable.

The Guidelines are also inconsistent. On the one hand, clause 1.6 provides that the fact that injury was ‘foreseeable or predictable’ or that the participant freely consented to participate should not exclude a participant from consideration for compensation. On the other, clause 4.2 undermines that assurance, by providing that compensation can be abated or excluded in light of (inter alia): the degree of probability that adverse reactions will occur; and any warnings given.

Only injuries attributable to participation in the trial are compensatable under the Guidelines. They specify a standard of the balance of probabilities, which is, as discussed, often an insurmountable barrier for participants to satisfy. If the investigator undertakes the investigation to decide whether the injury has been caused by participation in the study in the first instance (often the case), or the sponsor contracts a doctor to do so, there is the potential for bias. The decision-maker should be independent of the sponsor and researcher to avoid this potential. Only the New Zealand Guidelines provide that where there is a difference of opinion as to whether the injury was attributable to inclusion of the subject in the trial, the sponsor will make available

110 NEAC, Ethical Guidance for Intervention Studies (1st ed, 2009), para 8.4; MNZ (n 89), cl 4.1.[3]
111 And Medicines Australia and the MNZ Guidelines do not apply to Phase IV studies, whereas the ABPI ones do.
112 Peart and Moore (n 103), 12; J Dawson and N Peart, The Law of Research: A Guide (University of Otago Press, 2002), 192. The compensation arrangement in the Insulin Variant trial, for example, was restricted to medical expenses for physical injury only, which clearly does not satisfy ACC-equivalence, see the Participant Information Sheet and Consent Form in the Insulin variant Trial, 7 (on file with the author).
113 NEAC (n 86), para 49; NEAC (n 88), para iii.
114 See for example Ethics Ref 13/NTA/219, Northern A Minutes 9 December 2014, 3.
115 See for example, Ethics Ref 15/NTA/171; Ethics Ref 15/NTA/184, Northern A HDEC Minutes 10 November 2015, 11 & 26; Ethics Ref 16/NTA/23, Northern B HDEC Minutes 16 February 2016, 24.
116 ABPI (n 49), cl 1.2.
at its cost the opinion of an independent mediator, but that opinion is not, however, binding. Even this leaves the sponsor with the option of declining the claim for want of proof of causation if the mediator’s decision is not to its liking.

The Preamble expresses a preference for ‘a simple and expeditious procedure’ for claiming compensation, but the Guidelines provide minimal detail about the claims process. No time limit within which the company’s decision must be made is prescribed. In New Zealand, after learning of the injured participant’s difficulties in the CRYSTAL trial, one ethics committee became concerned about the practice of insurance companies typically taking over the management of claims on behalf of sponsors. This leaves the subject in an unequal fight for compensation with an insurer without support from the sponsor, given the power imbalance between subjects and insurance companies. It began to seek assurances from sponsors via the investigator that participants would be adequately supported during any disputes with insurers in relation to a claim. It emphasised that disputes about compensation payable must be resolved between the sponsor and the participant, not the participant and the insurer. Again, ethics committees can do no little more than exhort sponsors to comply with such a commitment.

In determining the claim, the company is judge in its own cause, since it, or its insurer, is decision-maker of a claim to which it is also a party with a financial interest. If the company decides that no payment should be made, there is no appeal to an independent decision-maker. Where the company disputes quantum, the Guidelines recommend that the sponsor agree to seek the opinion of an arbiter at the company’s cost, whose decision on the appropriate payment is to be ‘given substantial weight by the sponsor’ (UK, Australia) or ‘is binding’ (New Zealand). There seems no defensible reason why arbitration should be limited to disputes over the amount of compensation, and not be available to those where the company decides that no payment at all should be made.

Thus, the industry guidelines are heavily slanted in favour of the company’s interests at virtually every turn. This is perhaps unsurprising since they were developed by the industry for its own use in situations touching its financial interest.

V. INFORMATION PROVIDED TO SUBJECTS ABOUT COMPENSATION

Subjects must give a fully informed consent to participate in biomedical research. One of the specific items about which they must be advised is the compensation arrangement in place in the event of injury. Hence, all the templates for information sheets

117 See MNZ (n 89), cl 1.2.
118 The Guidelines provide only that claims are to be made to the company via the investigator. The participant must authorize it to review medical records relevant to the claim. Thereafter, the company shall consider the claim ‘expeditiously’, see ABPI (n 49), cl 5.1.
120 See for example, Ethics Ref 15/NTA, Northern A HDEC Minutes, 16.
121 See ABPI (n 49), cl 4.3; Medicines Australia (n 85), cl 4.3; MNZ (n 89), cl 4.3.
122 See CIOMS (n 22), Appendix 2, para 23. For the UK, see the EU Regulation 2014 (n 28), art 29(2)(d) and RCP 2007 (n 41), paras 4.15, 4.28. Surprisingly, Australia’s National Statement does not itemise this as a specific matter about which information should be communicated to participants, (see n 59, para 2.2.6),
recommended by the ethics supervisory agencies in all three countries include the subject of the compensation arrangement in place as an essential item requiring explanation. One might expect that a participant’s lack of any legal entitlement to no-fault compensation in the event of injury would be a sufficiently important aspect to be explicitly and unequivocally spelled out in information sheets.

The UK’s NHS Health Research Authority’s suggested explanation in a participant information sheet in its preparation guidance for NHS-based research (where the NHS Indemnity is in place) is:

In the event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you may have grounds for a legal action for compensation against [name of Sponsor Organisation, NHS Trust, Private Clinic] but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).123

In breach of the RCP’s Guidelines that the situation regarding compensation for non-negligent injury should be detailed, there is no information about the possibility of an ex gratia payment.124 It is not clear how an injured subject would learn about its possible availability.

The recommended wording for commercial research is:

We will provide compensation for any injury caused by taking part in this study in accordance with the guidelines of the Association of the British Pharmaceutical Industry (ABPI).

We will pay compensation where the injury probably resulted from:

- A drug being tested or administered as part of the trial protocol;
- Any test or procedure you received as part of the trial.

Any payment would be without legal commitment. (Please ask if you wish more information on this). We would not be bound by these guidelines to pay compensation where the injury resulted from a drug or procedure outside the trial protocol or where the protocol was not followed.125

Commendably, this does disclose that the obligation is ‘without legal commitment’. But a potential participant could be forgiven for concluding (erroneously) that the ‘without legal commitment’ qualification applies ‘where the injury resulted from a drug or procedure outside the trial protocol or where the protocol was not followed’.

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124 RCP 2007 (n 41), para 4.28.
125 NHS Health Research Authority (n 123).
There is no explanation of a subject’s rights to compensation through the courts. Given their significance to subjects’ ability to receive compensation, it is suggested that the Guidelines should be provided to every potential subject in all interventional research, and the researcher take reasonable steps to ensure that their effect is understood. They are referred to, but no copy provided. It is questionable whether this minimal explanation is sufficient for informed consent purposes.

In Australia, the NHMRC has commissioned standardised Participant Information and Consent Forms. The recommended wording for a company-sponsored trial is:

There are two avenues that may be available to you for seeking compensation if you suffer an injury as a result of your participation in this research project.

- The pharmaceutical industry has set up a compensation process, with which the Sponsor [Full name of Australian corporate sponsor] of this research project has agreed to comply. Details of the process and conditions are set out in the Medicines Australia Guidelines for Compensation for Injury Resulting from Participation in a Company-Sponsored Clinical Trial. In accordance with these Guidelines, the sponsor will determine whether to pay compensation to you, and, if so, how much.
- You may be able to seek compensation through the courts.126

The purely voluntary nature of a sponsor’s obligation under the Guidelines could be more explicit through inclusion of the key phrase: ‘without legal commitment’. On its face, the explanation could be read as suggesting that the sponsor’s decision depends on the applicability of the Guidelines to the subject’s circumstances. The recommendation is that participants are to be given the Guidelines in Phase I and II studies only, but must otherwise request a copy.

For a New Zealand publically funded trial, the ethics committees’ template participant information sheet suggests the following explanation:

If you were injured in this study, which is unlikely, you would be eligible to apply for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.127

This explanation is more careful, ironically since the potential subject’s financial exposure is least where s/he has ACC cover. But, missing here is any explanation of a

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subject’s inability to sue a researcher and sponsor in a civil damages suit in exchange for ACC cover.\textsuperscript{128}

The following is the recommended text for a commercially sponsored trial:

\textit{What if something goes wrong?}

If you were injured as a result of treatment given in this study, which is unlikely, you \textbf{won’t} be eligible for compensation from ACC. However, compensation would be available from the study’s sponsor, [name of sponsor], in line with industry guidelines. We can give you a copy of these guidelines if you wish. You would be able to take action through the courts if you disagreed with the amount of compensation provided.\textsuperscript{129}

The essential message is that compensation ‘would be available’ from the sponsor ‘if something [was to go] wrong’. The striking omission is any indication that the sponsor’s obligation is legally unenforceable. Indeed, by blending together information about compensation pursuant to the Guidelines with that about negligence liability, it misleadingly represents the opposite. The natural reading of the last sentence is that it refers to a subject’s ability to dispute in court a sponsor’s decision as to the amount of compensation it is prepared to provide \textit{under the Guidelines}. In so doing, it implies that the sponsor’s obligation under the Guidelines is enforceable by a court in the first place. Subject to an argument made in Section VI, no court could \textit{compel} payment nor fix quantum pursuant to an unenforceable obligation in voluntary guidelines. The explanation is hopelessly muddled.

The importance of the Guidelines, which are not named, is downplayed; not even a summary of their effect is given. Participants must request a copy to receive one. Apparently, few do ask for and read them.\textsuperscript{130} Subjects presumably rely on the ethics committee’s scrutiny of the documents and its ethical approval. In the unlikely event that they read them, what would they make of them? If New Zealand ethics committees have wrongly concluded, as the template suggests, that the amount of compensation payable under the Guidelines could be fixed and enforced by a court, what hope is there for a potential subject to ascertain the true position? The likelihood is that their financial exposure would be completely unappreciated by them, unless and until they suffered an injury and sought compensation.

All except the UK recommended wording for industry trials is lacking in not clearly informing potential subjects that payment of no-fault compensation is legally unenforceable. Potential New Zealand subjects could well be misled into believing that compensation under the Guidelines could be legally enforced by a court. At the very least, if ethics committees continue to approve research on the basis of the Guidelines, they must insist that sponsors spell out accurately and in the clearest terms in information sheets a subject’s lack of a legal right to no-fault

\textsuperscript{128} See Accident Compensation Act 2001, s 317(1).
\textsuperscript{129} Health and Disability Ethics Committees (n 127), 3. Emphasis in original.
\textsuperscript{130} Advice to author from a member of a New Zealand ethics committee.
compensation, so that the issue becomes clearly part of the subject’s overall consent.  

VI. ALTERNATIVE RESPONSES AND OPTIONS TO ADDRESS THE FINANCIAL EXPOSURE OF SUBJECTS

This Part considers options available to injured subjects and ethics committees to respond to the failure of sponsors in both public and commercial trials to meet the ethical expectation of no-fault compensation. It also outlines what is argued to be the simplest, fairest, and most effective response.

A. Legal claims

Is there scope for an injured participant to argue that the recommended explanations in the current New Zealand information sheet template (if used) creates a legally enforceable obligation on a sponsor to pay no fault compensation, despite the ‘absence of legal commitment’ wording of the Guidelines?  

It is possible to do no more here than sketch possible legal arguments available to an injured participant. In 1997, Guest considered that it would be ‘difficult to establish a contract in the absence of an express agreement with an individual subject. Particularly it would be almost impossible to establish the necessary “contractual intention” because of the “without legal commitment” wording [of the APBI Guidelines].’  

Certainly, courts have accepted that agreements expressed explicitly to be binding ‘in honour only’ are not legally binding for lack of an intention to create legal relations. Nevertheless, it might be argued that, despite the ‘absence of legal commitment’ wording, a binding contract has been concluded between the sponsor, entered into by the researcher as its agent, and the participant, based on the information sheet and signed consent form, as with UK commercially sponsored Phase I trials. If so, the sponsor would argue that the Guidelines are incorporated as a contractual document by reference to them in the information sheet, with the ‘without legal commitment’ references constituting an exclusion clause. The orthodox principle where contractual documents have been signed is that people are bound by the terms of documents to which they have put their signatures, irrespective of inadequate notice of an exclusion clause. But an exclusion clause will not operate if its effect has been misrepresented, whether or not the document has been signed.  

As has been argued, the standard text about compensation in the current New Zealand information sheet template for commercial

131 Failure to do so may expose committees’ members to an action in tort, see JV McHale, ‘Liability in the Law of Tort of Research Ethics Committees and their Members’ (2005) 1 Res Ethics Rev 53.
132 In response to the author’s criticism of the current New Zealand information sheet template, the chairs of the ethics committees advised that they have asked for its revision to make more explicit the voluntary nature of the sponsor’s compensation obligation, see letter from chairs of the Health and Disability Ethics Committees to author, 16 December 2016.
133 Guest (n 96), 183.
136 Curtis Chemical Cleaning & Dyeing Co [1951] 1 KB 805. See generally, Burrows, Finn and Todd (n 134), paras. 7.2.3 –7.2.4.
trials, in particular, misrepresents the true position, by representing that compensation enforceable by a court would be in place to protect subjects if something was to go wrong.

Another possible claim available to a New Zealand participant is promissory or equitable estoppel, based on representations in the current template information sheet (if used by the researcher and read by the subject). Unconscionability is the underpinning rationale of equitable estoppel, aimed at preventing unconscionable conduct and seeking to prevent detriment to the promisee.\(^{137}\) An injured participant’s theory of liability would be broadly as follows. Statements in the information sheet template constitute representations to potential participants, which induced them to assume that they would be financially protected by legally enforceable no-fault compensation in the event of injury. This is not a case of mere silence as to the sponsor’s lack of a legal obligation. The failure to disclose that fact, together with the misleading statements in the information sheet, amount to an actual misrepresentation that injured participants have a legally enforceable right to compensation under the Guidelines.\(^{138}\) Proof of detrimental reliance may present difficulties, since a participant would have to establish that, relying on the misrepresentation, s/he agreed to participate in the study, without which they would not have done so. As a result s/he suffered injury, only later learning that there is no legal right to compensation.

Is it reasonable for subjects to rely on representations in the information sheet that legally enforceable compensation would be available, without requesting and reading the Guidelines? Most do, it seems. There is nothing to put them on notice that the information is incorrect. They are surely entitled to rely on the information provided, having been vetted by an ethics committee prior to approval, as being reasonably comprehensive and accurate. Surely the onus is on the investigator and sponsor, whose duty it is to ensure that subjects give a properly informed consent to participation, to alert potential subjects to the voluntary nature of the sponsor’s obligation, by inserting a simple, explicit warning to this effect in the information sheet. Having not done so, the argument is that it would be unconscionable for the sponsor to be able to recant on the representation as to the availability of compensation enforceable by the courts, by relying on the ‘without legal commitment’ statement in Guidelines. Equity will intervene to avoid the detriment to the injured subject, by obliging the sponsor to pay compensation in accordance with the Guidelines as if they were legally binding.

B. Ethics Committees Refuse Approval in the Absence of Legally Enforceable no-Fault Compensation

Ethics committees could refuse ethical approval for clinical research in the absence of a legally enforceable, no-fault compensation arrangement put in place by the sponsor. In 1997, Guest noted that, since research cannot proceed without ethics approval, it

\(^{137}\) For the elements of the claim, see Krukzeimer v Hanover Finance Ltd [2010] NZAR 3017 (CA), para 38. See National Westminster Finance Ltd v National Bank of NZ [1996] 1 NZLR 548, 549 (CA); Waltons Stores (Interstate) Ltd v Maher (1988) 76 ALR 513 (HCA); Commonwealth v Verwayen (1990) 64 ALJR 540 (HCA); J Burrows, J Finn & S Todd (n 134), para 4.7.

\(^{138}\) See generally, Burrows, Finn and Todd (n 134), para 11.2.1(e).
was within the power of ethics committees to make their approval conditional upon adequate compensation arrangements being put in place. He advocated that all ethics committees lobby the ABPI for its patient-volunteer guidelines to be made identical to its healthy volunteer guidelines, i.e. legally enforceable by subjects, and that:

LRECs [Local research ethics committees] should be fully prepared, where risks are more than negligible, to refuse consent when legally enforceable no-fault compensation is lacking. 139

This advice remains as relevant for ethics committees in all three countries today as it was then, especially for Australasian participants in riskier Phase I studies. While their secondary function is to foster research, ethics committees’ primary duty is to protect participants. It is usual for laws, policies, guidance, or operating procedures to impose on ethics committees the duty to check that an appropriate compensation arrangement, supported by indemnity or insurance cover, is in place commensurate with the risk to participants in the trial. 140 Arguably, a compensation arrangement is only ‘appropriate’ if legally enforceable. Thus, ethics committees (or the institution) might be thought to be mandated to require companies to enter into legally enforceable arrangements to pay no-fault compensation as a condition of approval. It could justifiably conclude that a statement by a researcher that compensation would be available ‘in line with industry guidelines’ is insufficient evidence of the availability of ‘appropriate’ compensation and refuse approval, despite evidence of insurance which, while important, merely evidences ability to pay.

Ethics committees (or the institution) could start by requiring that sponsors put in place binding contracts between themselves and subjects to pay no-fault compensation, as for Phase I trials in the UK. The same simple procedure could be followed of the sponsor appointing the investigator as agent for the limited purpose of achieving this objective through an extended consent form. This suggestion has been made before, and was then resisted strenuously by the ABPI. It maintained that there were problems in establishing a legal contract with a patient-volunteer, such as the mental capacity of the patient, and that making the researcher a contractor would intrude inappropriately into the doctor-patient relationship. Guest powerfully rebutted these arguments: if patients are too ill to contract, then they must almost certainly be too ill to consent to participate. 141 The doctor–researcher must act in the patient-volunteer’s best interests, and it is in his/her best interests to have a legally enforceable compensation arrangement in place. All that would be required is a simple addition to the subject’s consent form. 142

139 Guest (n 96), 184.
140 For the UK, see EU Regulation (n 36), arts 76 and 7(1)(g). See also Standard Operating Procedures (n 39), paras 3.48 and Annex G, cls 1 and 2. For New Zealand, see NEAC (n 122), para 8.5 and Standard Operating Procedures (n 68), paras 147 and 149. In Australia, it is the responsibility of the institution as the approving authority to ensure that sponsors have put in place these arrangements, see National Statement (n 59), s 3.3.24.
141 The ABPI sees no difficulty asking researchers to contract with patient-volunteers in Phase I studies.
142 Guest (n 96), 184.
This approach would be most effective if governments supported ethics committees, by making it clear to industry an expectation that sponsors enter into legally binding arrangements to pay no-fault compensation in all industry trials. But, given the many other problems with the Guidelines, governments in each country should delegate to their leading ethics bodies the development of new, balanced and fair guidelines and standard contracts, which set out unequivocally a sponsor’s legal obligation to pay no-fault compensation. Ethics committees would then require their use as a condition of approval, instead of the current, biased, industry-drafted guidelines. A disadvantage is that this option would throw the clinical trials industry into turmoil in the short-term, as no clinical trials could proceed until legally enforceable compensation arrangements had been agreed. But it is suggested that this is preferable to the status quo, in which it appears that subjects are often ignorant of their lack of financial protection until it is too late.

C. A no-fault compensation fund

It is submitted that a no-fault fund would provide the most satisfactory means of compensating for research-related injury. Such a system pays compensation to a defined group of injured people (injured research participants) from contributions pooled into a collective fund. Independent medical experts would review the injury to determine whether injury was attributable to participation in the research and eligibility for compensation. A finding of injury related to the research would trigger the compensation mechanism. Depending on the extent of funding, levels of compensation could relate to damages awards in the courts for similar injuries. But, at a minimum, compensation for medical expenses, disability, economic losses, and benefits for dependents in the event of death should be available. The scheme would operate outside the tort system via a fund administered by body such as a board. While it would always be open to a participant to sue in negligence (except in New Zealand), acceptance of compensation from the fund would preclude a tort action. A simple claims process and timely determination of claims are important features, as well as an independent appeal mechanism. Financial responsibility for the fund would be shared among those who benefit directly from research, such as the public health service, research funding bodies, universities, research institutions, the medical protection societies, pharmaceutical companies, and other private funders. An aggregate fund is much more economical than individuals and organisations being left to make independent insurance arrangements. Ultimately, however, because society as a whole benefits from people’s participation in research, it is submitted that society itself via taxpayers should fund such a scheme, which could then be secured on a statutory basis, as in New Zealand.

Compensation is not, of course, the only objective of an accident compensation system, whether tort law or ACC. There are also legitimate societal goals of corrective justice, including accountability, and deterrence/accident prevention. There is a valid

143 Governments in all three countries have professed aims of encouraging growth in their commercial trials industries.
144 See the suggested fund put forward by the Ciba Foundation study group, ‘Medical Research: Civil Liability and Compensation for Personal Injury — a Discussion Paper’ (1980) 280 BMJ 1172.
concern that a no-fault system will blunt sponsors’, researchers’ and institutions’ incentives to conduct safe studies. In particular, detractors might argue that no-fault would weaken incentives on commercial sponsors particularly to consider carefully what research to undertake and to manage and minimise its associated risks. This is so, it is argued, since they are not required to internalise the true costs of participant injuries in their trials in their financial risk-benefit calculus, but are instead permitted to shift those costs on to the scheme. The obvious means of maintaining appropriate levels of deterrence is by charging levies or premiums calibrated to a sponsor’s or institution’s safety record and claims experience (‘experience-rating’). A further possibility is that, if entitlements have been paid to injured participants, the fund could be given a statutory or contractual right of subrogation to pursue any legal claim against the sponsor that the subject may have. As well as to recover its costs, the purpose would be to promote effective deterrence, so that sponsors are incentivised to prioritise safety in their trials by the prospect of a civil action brought against it by the fund. It would have a discretion to determine which claims it chose to pursue, such as those where its costs were particularly high, or where the sponsor’s conduct was grossly negligent.

**CONCLUSION**

Future patients and society benefit from individuals’ participation in biomedical research. Because all clinical research, even therapeutic research, requires participants to assume a position of risk for the benefit of society, the beneficiaries of research (researchers, sponsors and society) have a moral responsibility to compensate for research-related injury. Tort law is an unfair system of compensation for research-related injury, because, despite undertaking the risks of the research in the interests of others for no or uncertain individual benefit, injured participants are almost always left to bear the full financial burden of their injuries alone. No-fault compensation is the best ethical response to research-related injury, as only no-fault compensation will adequately protect participants in clinical trials in respect of injuries for which negligence cannot be established.

The three countries surveyed here have been found wanting in the extent to which they measure up to this ethical requirement. Except in publically sponsored trials in New Zealand and Phase I studies in the UK, research participants are generally required to rely on a legally unenforceable assurance of compensation or *ex gratia* payment in the event of injury. Because of the absence of explicit disclosure of this key fact in the wording of some information sheets recommended by ethics supervisory agencies, many subjects will enrol in clinical research in ignorance of this and of their consequential financial vulnerability. As a first step, ethics committees must demand that sponsors and researchers spell out unequivocally the lack of legally enforceable no-fault compensation in information sheets and take reasonable steps to ensure that subjects understand its implications, so that they give a properly informed consent.

Ethics committees have the power to withhold their approval of clinical trials in the absence of evidence of a legal entitlement to no-fault compensation. Such a drastic course of action would wreak havoc on the industry, and so may be best reserved for trials where the risk is more than minimal or as a last resort, should governments fail to act. Industry guidelines used in all three countries have been drafted by industry to

Downloaded from https://academic.oup.com/medlaw/article-abstract/25/3/397/3769302/Does-the-Law-on-Compensation-for-Research-Related-Injuries... on 06 September 2017
protect its interests. If reliance on non-legislative guidelines is to continue, these need to be re-drafted, so as to be made legally enforceable, fairer and more balanced, a role for which key ethics bodies are ideally suited. Governments need to make it clear to industry that legally enforceable, no-fault compensation is the price of continued self-regulation. But, it is suggested that the most ethically defensible and efficient reform option for compensating for research-related injury is to establish an aggregate no-fault compensation fund. The ethical corollary of the fact that society is the ultimate beneficiary of its members’ participation in clinical research, is that the fund be financed and administered by the state. New Zealand operates such a scheme, its only (albeit serious) policy misstep being that it is unavailable to injured participants in industry trials.