



Commentary

Involuntary experiments in former colonies: The case for a moratorium

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ABSTRACT

There is a rich literature on the use of medical trials as a model for designing and evaluating the outcomes of social policy interventions in former colonies. Yet social experimentalists have not engaged in a correspondingly vibrant discussion of medical ethics. A systematic review of social experiments shows that few studies explicitly discuss informed consent, or the serious constraints on securing informed consent from impoverished or child participants, particularly in the context of cluster randomization. The silence on informed consent, and in some cases active denial thereof, suggests that it is often considered less important than other elements of experimental design. This matters since involuntary experimentation on vulnerable people violates their personhood, increases the risk of unintended harm, and establishes continuities with colonial experimentation. There is a need to develop more effective mechanisms for regulating social experiments in former colonies. In the interim, scholars in the South have a responsibility to call for a moratorium on experiments.

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Racialised and impoverished people have long borne the brunt of involuntary experimentation (Washington, 2006). During the Nuremberg Trials, the principle of informed consent became a matter of international concern when Nazi scientists were prosecuted for subjecting people to involuntary and often fatal experiments. This principle was subsequently incorporated into the International Covenant on Civil and Political Rights as one of the “inalienable rights of all members of the human family ... derive[d] from the inherent dignity of the human person.” (United Nations 1966, quoted in Schuman, 2012) This framing conceptualises the absence of informed consent as a violation of personhood in and of itself, outside of any negative consequences it enables.

Yet rights are always contextual, always struggled over. One of the ironies of this period is that while the United States prosecuted Nazi scientists for conducting involuntary experiments, its Public Health Service had been conducting the Tuskegee Study of Untreated Syphilis on unconsenting black men from 1932 to 1972 (Washington, 2006). And involuntary medical experimentation on impoverished people in former colonies persists to this day (Schuman, 2012).

I preface my remarks with this brief medical history since there is a rich literature on the use of medical trials as a model for designing and evaluating the outcomes of social policy interventions in former colonies. Yet social experimentalists have not engaged in a correspondingly vibrant discussion of medical ethics. In particular, they have largely been silent on informed consent.

To make this claim, I draw on a systematic review of all randomized controlled trials published between 2009 and 2014 in ‘top economics journals’ conducted by Peters, Langbein, and Roberts (2016).¹ I use their review because it indicates the standards of journals considered to be the most rigorous in the discipline. It is plausibly an ‘upper bound’ on the ethics of experimentation. Since the original review only extracted general information on participant awareness as a threat to external validity, I add information on informed consent, country focus and author location.²

Peters et al. (2016) find that 46% of the studies discuss whether participants were aware that a study was being conducted (even if participants did not consent). I then disaggregate by region: participant awareness is discussed in 65% of experiments conducted in Europe and the United States, compared with 34% of experiments conducted in Africa, Asia and Latin America – all former colonies. This suggests a troubling difference in ethical standards (Table 1).

I now focus on studies conducted in former colonies, which constitute the majority under review. How many explicitly secured informed consent? For this, I use one criterion: participants knew they were in some sort of study before agreeing to participate.

¹ Peters et al. (2016) focused on eight journals: *American Economic Review*, *Econometrica*, *Quarterly Journal of Economics*, *Journal of Political Economy*, *Review of Economic Studies*, *Economic Journal*, *Journal of Public Economics*, and the *American Economic Journal: Applied Economics*.

² This data was gleaned from the online appendix, which contains a list of all the papers reviewed. I extracted information on informed consent and country focus from each article. I identified the institutional location of first authors from the author notes in the article, or if this was missing, by conducting a Google search. I then coded each institution by country and region.

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Table 1
Articles discuss whether participants were aware of the study.

	% no	% yes	Total	N
Western Europe and United States	35	65	100	34
Africa, Asia and Latin America	66	34	100	58
Other regions	0	0	0	0
Total	54	46	100	92

By this criterion, 78% of authors do not discuss informed consent, 12% state that participants were intentionally left ignorant, and 10% indicate informed consent for some sort of study. No study indicated whether participants were explicitly aware they were being experimented upon. This silence on informed consent, and in some cases explicit denial thereof, suggests that it is considered less important than other elements of the experimental design (Table 2).

Moreover, the experimental design of these studies raises serious concerns about whether participants were able to consent. 64% randomly allocated treatments to clusters, such as schools or clinics. Yet no study discussed whether participants could not opt out because it was costly to leave the cluster, and how this was addressed. Furthermore, 16% used children directly as participants, yet only one study explicitly gained the consent of parents. Finally, nearly all the studies used impoverished participants, but no study discussed whether penury compelled people to participate. These substantial constraints to informed consent suggest that it may have been difficult or infeasible to secure informed consent in the majority of these studies.

The suspension of informed consent is consequential. First, it “raises the subtle but important distinction between treating human beings as wilful agents who have a right to participate or not as they so choose, versus treating them as subjects to be manipulated for research purposes.” (Barrett & Carter, 2010, 520). It violates the personhood of some of the world’s most vulnerable people – impoverished black and brown people, many of whom are women.

Second, it increases the risk of unintentional harm. If participants are aware of the true nature of the intervention, its risks and trade-offs, they may be able to alert experimentalists to unintended negative consequences. This is important for experiments that allocate critical resources, such as income or healthcare, to impoverished people. Withholding or providing resources to particular groups may harm vulnerable groups or catalyse contestations that are socially destabilising (Acemoglu, 2010).

Third, it increases the risk of establishing historical continuities with colonial experimentation. While many colonial experimentalists hoped to help the lives of the poor and contribute to science, their experimentation was often involuntary and harmful, and had the effect of positioning entire regions as though they were “living laboratories” in which scientific curiosity and the urge for beneficence could be satisfied (Tilley, 2011). Stark regional asymmetries in authorship heighten this risk. Of the experiments conducted in former colonies, 84% of lead authors were at

institutions in the United States or Western Europe. No first authors were located in Africa or Latin America and 5% were in Asia (Table 3).

The suspension of informed consent in social experiments is typically a response to the problem of external validity (Barrett & Carter, 2010). If participants know that they are in an experiment then they may behave differently than they would under non-experimental conditions, so that the outcomes of an intervention might not scale up to a population. Yet the standard solution in medical research – assigning a placebo – is not possible in most social experiments. Thus, there is a *prima facie* ‘greater good’ argument for violating informed consent – it helps ensure the external validity of experiments in order to contribute evidence for more beneficial policies.

With or without informed consent, however, social experiments face serious problems of external validity (Heckman, 1992; Deaton, 2010; Muller, 2015). And even if experimental results could generalise to different people or times, this assumes that experiments lead to more beneficial policies than alternative forms of research. This is a counterfactual claim for which no experimental evidence has yet been forthcoming (Chelwa & Muller, 2019). Indeed, the role of medical experiments in harmful outcomes, such as the opioid crisis, cautions against strong claims about policy benefits (Deaton, *in press*).

Adopting a less ambitious, more cautious approach may help investigators attend more closely to ethical requirements, but more is needed. As with medical experimentation, social experimentation requires regulatory oversight. Reflecting on his own role in conducting experiments, Sarin (2019) examines harmful and potentially illegal experiments that were approved by university review boards. In light of this, he urges the 2019 Nobel laureates to call for halting all experiments on vulnerable people until effective ethical safeguards are established.

Table 3
First author location of experiments conducted in former colonies.

	Frequency	Percentage
Africa	0	0
Asia	3	5
Europe	10	17
Latin America	0	0
United States	39	67
World bank	6	10
Other	0	0
Total	58	100

Table 2
Features of experiments in former colonies related to informed consent.

	% not stated	% no	% yes	total
Participants consented to participate in some sort of study	78	12	10	100
Participants aware that they were in an experiment	100	0	0	100
Cluster randomization	0	36	64	100
Impoverished subjects	0	3	97	100
Child subjects	0	84	16	100
Addresses design constraints on ability to opt out	100	0	0	100
Approved by university ethical review board	91	0	9	100

This is an important intervention, but it fails to account for the responsibilities of southern scholars to our societies, and elides the role that southern scholars have played in enabling unethical experimentation. It is *our* responsibility to insist that experiments in our societies follow rigorous ethical protocols, and we should be at the forefront of ensuring this is enforced.

As with medical experimentation, however, existing mechanisms for regulating social experimentation are likely ineffective. Social experimentation has rapidly become a multinational enterprise, one with significant financial and political interests (Jatteau, 2016). J-PAL, which propelled the rise of this industry, has a model of policy influence that focuses on driving demand by “co-creating” experiments with governments, NGOs and funders (Gyamfi & Park, 2019). Thus, key institutions, which might have held experimentalists accountable, are no longer at arm’s length from the research and their will to enforce ethics may be undermined by a conflict of interests (Hoffmann, 2018).

Securing informed consent is crucial to upholding the dignity of vulnerable people, reducing the risk of harm, and mitigating continuities with colonial experimentation. To this end, it will likely require new models for regulating this multinational industry, which involve southern scholars and governments working collaboratively. Yet as ongoing involuntary medical experimentation shows, the precise details of this require careful thought. In the interim, scholars in the South have a clear responsibility to call for a moratorium on experimentation. Racialised and impoverished people deserve the same protections and dignity that are afforded to wealthy and white people.

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