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Community, Context and the Contrasting Roles of Clinicians and Researchers: Challenges Raised by Statutory Rape

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The scope and limits of responsibility in the context of human subjects research are more complex than many researchers (and subjects) typically think (Easter et al. 2006). Many factors contribute to such complexity, including that the functions of clinicians and researchers are often indistinguishable, even while their focus and aim are quite distinct (a point well established since at least the *Declaration of Helsinki*, reiterated in *The Belmont Report*, and ingredient to current federal regulations governing institutional review board (IRB) function). In the most general sense, the care and well-being of an individual patient serves as a clinician's focus whereas for a researcher, the generation of "good data" frames one's practices. Despite considerable effort to separate the functions and the people who carry out each function, confusion between the role of "clinician" and "researcher"—and between "patient" and "subject"—remains all too common, as do the obligations associated with each role. This is often true among clinical researchers; those who review, approve, and oversee research (IRBs, data safety monitoring boards, etc.); and for study subjects (Liddle 1967).

We draw attention to this issue of role confusion and to the parallel fact of differences in role responsibility, because the issue of whether to report statutory rape in the context of a research study as presented here is susceptible to similar complexity and confusion. Several issues need further examination to clarify how to answer the question of the obligation to report.

First, we acknowledge that researchers' legal and ethical role obligations are distinct (even if intertwined). There certainly *appears* to be little legal uncertainty that the sexual contact here is child sexual abuse and must be reported because the age difference between the pregnant adolescent girl and the fetus' father is greater than 4 years. What is not clear is whether this legal obligation is absolute in all contexts and circumstances.

For instance, when developing this study, researchers might have (and we suggest *should* have) anticipated this possibility of the mother-father dyad satisfying the statutory rape criteria (Bunting and McAuley 2004). Accordingly, the researchers could have sought input from local courts, Child Protective Services, and other legal entities to learn possible options

for responding when such situations arise. By doing so, they would have been prepared to satisfy the need for protecting adolescent mothers (the basis for the legal requirement to report) as well as the (assumed-to-be-justified) need for performing this research. For the same reasons, a similar responsibility for contacting these kinds of legal and social agents rests on the shoulders of the IRB charged with reviewing this research prior to approval.

This case illustrates how the seemingly simple and straightforward legal obligation to report demands deeper exploration. Obligations more traditionally identified as “ethical” too are multidimensional. For instance, the pledge of confidentiality is undergirded by a commitment to be worthy of the trust given, meaning the researchers, and by implication, the institution that reviewed (through its IRB) the research must demonstrate such trustworthiness. There is considerable experience with research on illegal behaviors, especially in addiction, in which confidentiality rules protect subjects (Fitzgerald and Hamilton 2006). Similar confidentiality rules ought to have been incorporated into this study.

While this case provides little contextual information, we surmise some features that highlight the challenges for understanding the breadth and depth of ethical obligation. Consider the aim of this study: to evaluate a co-parenting intervention for pregnant adolescents and their partners. Given the well-established evidence that adolescents from lower socioeconomic groups have higher rates of pregnancy (Penman-Aguilar et al. 2013) and that children born into lower socioeconomic contexts experience greater health issues (Bradley and Corwyn 2002), it is reasonable to conjecture that the targeted subjects were adolescents in lower socioeconomic contexts.

This draws attention to another dimension of the issue of responsibility. Researchers do not shoulder the weight of responsibility alone; IRBs can and *should* play a significant role. At a minimum, adequate review of the scope of risks and potential harms for a study drawing subjects from a community that differs from those who propose and review the research demands explicit and direct outreach to that community—ideally during the earliest phases of developing the research, and certainly as part of the review and evaluation of the research (Baker et al. 1999). Doing so provides opportunity to develop an appreciation of how risks and harms are understood within that community as well as what kind of activities and relational dynamics are taken as norms, thereby allowing greater likelihood of respecting the community social custom regarding, for instance, reporting when the biological father remains with the family.

This latter point is not meant to collapse ethical evaluation into relativism. Rather, the point is to highlight the need to develop sensibilities for differences concerning how those whom we study understand not merely the fact of our studying them, but their own experiences in being studied. We are required to do this when pursuing international research and interventions in cultural contexts vastly different from our own, such as developing countries (Emanuel et al. 2004). The same should be done here at home. Indeed, community-based IRBs are beginning to be formed to ensure there is appropriate partnering between researchers and communities in creating community-based research proposals so that cultural sensitivities are more clearly represented (Shore et al. 2011).

The upshot of all of the above is that research will be better, and better accepted, not only when we avoid confusing responsibilities we have as clinicians with those we have as researchers, but when we more actively involve the communities from which we draw research subjects. We will be better prepared to answer questions such as whether, and to whom, we have an obligation to report potential sexual abuse disclosed in a research study. As for this case, although there is no indication that the researchers proactively sought input from their local court system and Child Protective Services (as they should have), nor does it seem that they engaged the community from which they hoped to enroll subjects (as they should have), they nonetheless still have the opportunity to do so.

Accordingly, upon learning of the age difference between D and her partner, the researchers' first steps should be to go to community organizations connected to D, her partner, and their families. The aim for doing so is to learn how D's community understands such couplings and the ways in which they help and protect young women such as D (as well as the children they bear). What the researchers do next will depend on what they come to learn. The crucial point is that acting responsibly in this context demands reaching out to, and learning from, D's community. This community—of which she, her partner, and their families are part—provides crucial contextual grounding for understanding what it actually means, practically as well as morally, to “protect” or “care” for D—as research subject, as patient, and as a human being.

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