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Political Psychology and Critiques of the Scientific Method: AZT, Asia, Africa

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Title: Political Psychology and Critiques of the Scientific Method: AZT, Asia, Africa

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Abstract. This article critiques critiques of clinical outcome studies carried out in Third World countries of Asia and Africa for new methods of AZT treatment that might affect the transmission of HIV from pregnant women to their infants. Some of these studies have been supported by the United States' Centers for Disease Control (CDC) and National Institutes of Health and opposed by several articles in The New England Journal of Medicine.

Critiques of the applicability of clinical outcome studies involving AZT treatment that might affect HIV transmission from pregnant women to their infants in the Third World countries of Asia and Africa most often cite that AZT treatments are not practical because of (1) high monetary cost, (2) scarcity of medical equipment, (3) infrequency of seeking or being offered prenatal care, and (4) cultural resistance to refraining from breastfeeding. To address these concerns, researchers have attempted to develop shorter, simpler, less costly, and more culturally appealing AZT treatments.

However, addressing these concerns has led to greater focus on an additional one. Does the use of a control group that receives a placebo necessarily doom this group to a higher rate of HIV transmission from mother to baby than an experimental group receiving AZT? And if so, should such research not occur?

Opponents of using control groups and placebos maintain that scientific standards for evaluating hypotheses that are appropriate for research in the laboratory may not be appropriate for clinical research. These opponents challenge the ethics and morality of those supporting control groups. The supporters, however, maintain that an experimental-control group comparison for measures of dependent variables is the most direct means of demonstrating that an AZT treatment will be worth the expenditure of precious Third World health dollars. Moreover, as researchers attempt to identify the shortest, simplest, least costly, and most culturally appealing treatment, the difference between the measures of independent variables for experimental and control group will continue to decrease. Even if a placebo is not used, necessarily some ineffective AZT amount or procedure will be.

A counter to the counter of supporters is that there are alternate (if not optimal) methods of comparison: for example, providing AZT to all research participants and exploring the incidence and prevalence of HIV transmission for this sample or samples with other segments of the population not in the study. And here lie the seeds of what becomes a non-problem, a non-tension between "good" science and moral and ethical values. (Of course, "good" science includes "good" moral and ethical values.) For whether all subjects in a study receive AZT or not, there will be people--outside the study, outside the country, outside the hemisphere--who won't be. Should clinical researchers be morally and ethically constrained from doing outcome research until all who live on the planet can receive the allegedly effective treatment? And if this were to be the case, what would happen if the treatment was associated with no effect or even untoward consequences? Opponents of control and placebo groups often communicate as if all sensible people would choose the experimental drug if there were a choice--as if such sense could not turn to nonsense.

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The narcissistic and economic gratification that can occur with scientific triumph will quickly turn to defeat if therapeutic claims prove to be unfounded. And most researchers attempting to develop effective treatments are not employing optimal versions of scientific method for aesthetic pleasure and compulsive compromise of intrapsychic conflict. Instead, they are moral and ethical beings familiar with the victories and defeats, the epiphanies and tragedies of public health research, intervention, and evaluation. However, hubris, racism, and even evil can lurk behind a seemingly benign façade--both for supporters and opponents of specific public health initiatives. (See Hellman, D. (April 27, 1998). Trial and error. *The New Republic*, 14; 16-17; Lambert, M.J., Okiishi, J.C., Finch, A.E., & Johnson, L.D. (1998). Outcome assessment: From conceptualization to implementation. *Professional Psychology: Research and Practice*, 29, 63-70; Leslie, J.C. (1996). The "data collection dilemma": An ethical Issue for all psychological research. *Irish Journal of Psychology*, 17, 148-155; Martinovich, Z., Saunders, S., & Howard, K.I. (1996). Some comments on "Assessing clinical significance." *Psychotherapy Research*, 6, 124-132; Mohr, D.C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1-27; Siegel, K., & Gorey, E. (1997). HIV-infected women: Barriers to AZT use. *Social Science and Medicine*, 45, 15-22.) (Keywords: Interpretation, Moral.)