The Five Assumptions That Undermine Global Clinical Trials

The biggest risks to a global study occur long before the first patient is enrolled.

The illusory ideal for every sponsor running a global study is to manage one programme built around a single protocol, data package and regulatory strategy that runs universally across every market and region. The reality is far more complex because a global trial is not simply one study happening simultaneously in several places. It is composed of several regional programmes, each running under their own regulatory systems, site relationships and often their own timelines, that a sponsor likes to perceive as a single study.

While a protocol summary may be framed as a single study, the operational execution is quite another matter. For instance, a protocol amendment in one region delays site activation in another. Or a sponsor discovers that a regulatory pathway they assumed was standard has changed since the last time anyone on the team actually ran a study in the region. This is how the strategy of a global trial collides with the reality of local execution and it can easily trip up studies.

None of this means that the global strategy itself is wrong. Sponsors pursue multi-regional studies for good reasons. It can give broader patient and market access, lead to much faster enrolment timelines (particularly for rare diseases) and provide the diverse patient populations that regulators increasingly expect in the pivotal data. A global strategy works best when the execution model is designed to recognise that local operational realities will inevitably change as the study progresses.

False Assumptions About China Timelines

China is the perfect example of where sponsors have misconceptions that can significantly impact the success of a study. The country has recently surfaced as a popular region for conducting studies. But many sponsors still make contradictory assumptions about starting a trial there. Ask how long it takes to start a trial in China and all too often, you will still hear a number that reflects the industry as it existed five or ten years ago rather than as it exists now. A few years back, sponsors reasonably budgeted somewhere between 11 and 14 months of startup time before a China site could begin enrolling, a figure driven largely by the pace of regulatory review under a much less modernised approval process. That number has changed substantially in the last 12 months. We're now routinely seeing startup timelines that average closer to 6 to 7 months and sometimes as fast as 5. Sponsors still planning around the old figure tend to make one of two mistakes: 1) writing China out of the strategy too early, assuming it will slow the program down, or 2) building in so much schedule padding that they lose the competitive advantage speed was supposed to give them in the first place.

Multiple factors account for this new reality. Regulatory reviews in China genuinely got faster, but so did quality at the site and investigator level, along with the basic mechanics of running a trial at the site level, communication with sponsors and the data exchange systems that make a study auditable. Each clinical site in China is government owned rather than the academic and private mix common in the US and EU, and studies are typically supported by commercially motivated site management organisations operating inside those hospitals, handling patient recruitment and day to day site setup as a dedicated business function rather than an afterthought. Add a population large enough that even a comparatively rare disease indication has a substantive pool of eligible patients and it becomes easier to understand why enrolment in China has become fast.

The opposite mistake is just as common. Sponsors who have heard that China moves quickly overlook the fact that speed still depends on site selection, investigator relationships and regulatory submissions prepared correctly the first time. In fact, it depends on how well the team running the study understands the system as it exists today, not as it existed five years ago. Thus, a sponsor's assumption about timelines is usually the first place a global study starts to drift from its own plan.

Enrolment Does Not Behave the Way Sponsors Expect

The second assumption sits inside the enrolment plan. Sponsors frequently model a global study as though every region will contribute patients on a roughly parallel schedule. In practice, regions come online at different points, often for reasons that have nothing to do with how well any individual site is performing. A region added later in a programme is dependent on decisions made earlier in other regions. This includes protocol amendments, endpoint definitions and regulatory submissions finalised before that region's sites were ever activated.

This matters because a sponsor's confidence in an enrolment forecast is often based on treating each region as an independent input when the regions are sequential and interdependent. A study designed with every region's regulatory and operational reality considered from the earliest stage of protocol development behaves very differently than one where a European based protocol is finalised first and exported outward, with each new region expected to fit itself around decisions it had no part in shaping. The sponsors who get enrolment forecasts closest to reality tend to be the ones who brought regional expertise into study design at the beginning rather than adding it after the protocol was locked.

Sponsors Misunderstand the Risk They Are Managing

There is yet another kind of false assumption sitting underneath the operational ones and it concerns what sponsors believe they are risking by working in China at all. For years, hesitation about the region was usually framed as a concern about GCP compliance or data quality. In reality, the real concern was just as frequently about intellectual property. Sponsors wondered whether a molecule's underlying science could be reverse engineered once it left its own regulatory environment and whether patent protection would hold up.

That concern is easing, for reasons that have little to do with clinical operations. Regulatory alignment with ICH guidelines

and FDA standards has closed much of the compliance gap that once separated China from Western expectations. At the same time, a growing share of the US biotechs running these studies are founded or led by individuals with direct professional ties to China, who carry a working familiarity that an outside sponsor evaluating the region for the first time has not had time to build.

The Assumption that a Bigger Name Means Less Risk

The fourth assumption shapes the most consequential decision in the entire process. The choice of which partner actually runs the study has a significant impact on the likelihood of success of the study. Sponsors reasonably want to reduce risk, and a common shortcut is choosing the CRO with the most recognisable brand name and the broadest global footprint. Certainly, the logic feels sound. A larger organisation comes with greater infrastructure and people experienced in managing complexity.

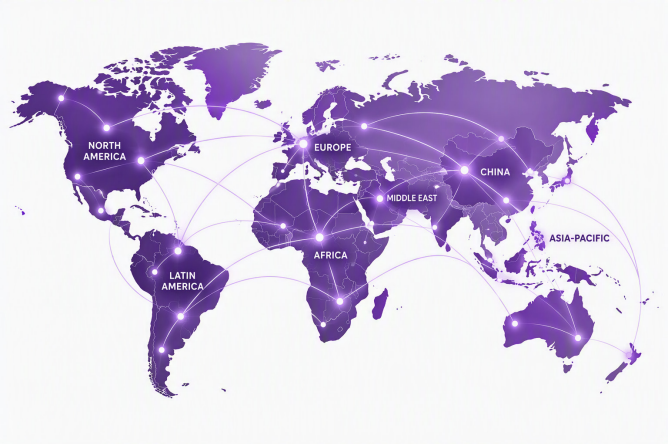
However, what that logic misses is how a large, generalist CRO actually allocates its focus in. A biotech sponsor running a mid-sized study is one account among many, competing internally for time and resources against much larger programmes from much larger clients with larger budgets. Systems built to manage dozens of therapeutic areas are often not ideal for the regulatory or scientific nuance of any single one. And that is the problem with brand recognition. It does not measure an ideal fit. It tells a sponsor how well known an organisation is, but not whether it has the regional relationships, therapeutic depth, or the operating model a particular study needs.

Fortunately, there are specific CRO capabilities that actually help sponsors reduce execution risk and it has nothing to do with their size or brand recognition. Instead, it includes having regional operational expertise built over an extended period of time, scientific and therapeutic expertise that is embedded in protocol design and an operating structure where regional and global teams function as one group instead of separate vendors potentially fumbling a study handoff between each other. The reality is that therapeutic-area investigator and regulatory relationships built over a decade or more by the CRO tend to produce faster, more reliable site selection.

Data Quality Questions Are Not Considered Early Enough

The fifth false assumption tends to surface last, usually during a regulatory submission rather than during the trial itself. Sponsors with limited global experience often assume that if a region's portion of a study meets that region's own regulatory standards, the data will simply slot into a global submission without further scrutiny. But locally compliant and globally contributory are not the same standard and treating them as interchangeable is how sponsors end up with data that satisfies one regulator while unfortunately raising questions with another.

Data becomes globally contributory only when endpoints, patient population definitions and data standards are aligned across every region from the point the protocol is written, rather than being reconciled after each region has already collected slightly different datasets. This happens by deliberate design and it depends on the same elements the earlier assumptions depend on, including whether the teams running each region were part of the study's design from the start or are they handed a finished protocol and asked to make it work locally. A sponsor usually discovers which of those two things happened only when a regulator asks a question the data was not built to answer. What is really at stake: getting new cures to patients faster. None of these illusions are abstract, and the cost of getting them wrong is not small. Estimates



vary, but a single month gained or lost on the way to market can plausibly represent tens of millions of dollars once commercial timing and competitive positioning are factored in. A sponsor who closes a three-to-six-month enrolment gap in a late phase study is tangibly changing where and when their asset lands relative to a competitor competing in the same indication.

For biotech sponsors specifically, the stakes are even more pronounced. Early phase data exists to specifically increase the value of an asset enough to support a transaction, a public offering, or the next funding round. A sponsor racing toward a specific milestone, an interim analysis, a filing, a funding round, does not have the luxury of absorbing a timeline miscalculation quietly. A month lost to an outdated assumption about a region's startup time shows up directly in the next conversation with investors.

A sponsor who selects a study partner based on name recognition alone, without matching that decision to what the specific study actually needs, usually does not discover the gap until the study is already running, at which point the cost of changing course is high.

The promise behind a global clinical trial is real, though risk is often introduced by poor planning and false assumptions about timelines, about how enrolment arrives and the misunderstanding the value a CRO brings. These issues can be addressed by properly matching a study's regional, therapeutic and operational needs with the right CRO partner who genuinely has the ability to delivery them and from being honest about which assumptions are built on current data and which were simply carried over from the last study.

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