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Clarence J. Sundram

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IN HARM'S WAY: RESEARCH SUBJECTS WHO ARE DECISIONALLY IMPAIRED

CLARENCE J. SUNDRAM*

I. INTRODUCTION

The term "decisionally impaired" covers a wide variety of conditions that compromise an individual's ability to make knowing, intelligent, and voluntary decisions about matters that could have serious consequences on his or her health, safety or welfare. These conditions can be temporary, as in the case of childhood or unconsciousness; episodic and intermittent, as in the case of serious mental illness; or permanent, as in the case of severe or profound mental retardation and the late stages of Alzheimer's disease, AIDS dementia, Huntington's disease, and other similar conditions.

This article will address the issue of decisional impairments caused by serious mental illness in the context of biomedical research involving human subjects. The decisionally impaired seriously mentally ill person shares, in common with other groups of decisionally impaired individuals, an inability to weigh the risks and benefits of proposed research, and to reach a knowing, intelligent and voluntary decision regarding participation in such research. However, there are aspects of serious mental illness that distinguish it from other cognitively impairing conditions.

The nature and course of serious mental illness, including its onset, commonly in late adolescence or early adulthood, and its fluctuation from periods of acute psychosis to periods of relative remission, place particular demands and strains upon relationships with family and close friends.¹ These strains in turn affect the acceptability, availability, and reliability of family surrogates in the decision-making process. Such strains and their effects are not found to the same extent with other cognitively impairing conditions which are either of a short term nature (e.g., unconsciousness), a normal part of the life cycle (childhood), or which occur in an environment of stable family relationships (e.g., late stage Alzheimer's disease).

* Chairman, New York State Commission on Quality of Care for the Mentally Disabled. The assistance of Kathryn McKee, Ph.D., in research for this article is acknowledged, with gratitude.

1. See generally HARRIET P. LEFLEY, *FAMILY CAREGIVING IN MENTAL ILLNESS* (1996).

Patients' attitudes towards their diagnosis of serious mental illness vary widely as well. Some patients recognize their mental illness, have generally positive experiences with mental health treatment, and welcome and assist in efforts to improve the understanding of their illness and methods of treatment.² Other patients challenge their diagnosis, see treatment as coercion, and report bad and abusive experiences in mental health facilities which they see themselves as having "survived."³ Some patients view their families as their natural allies and most reliable and enduring support system. Their families represent their interests when they are unable to. Others see their families as adversaries who are allied with those who would coerce them into unwanted and unnecessary treatment. The views and attitudes of persons with serious mental illness are not fixed and static, but may move to different points between these poles as their family relations, clinical condition, relationship with professionals, experiences with treatment, and a variety of other influences affect them.

II. CONTEXT

The environment in which questions about research involving decisionally impaired and mentally disabled individuals arise is extremely important to an understanding of the issues presented. The mentally disabled have always been near the bottom of the totem pole in most areas of public policy. There are numerous examples of policy issues where persons with mental disabilities are treated unfavorably compared to others with severe and chronic illnesses. For example, insurance policies typically place different and tighter restrictions on coverage for mental illnesses compared to those with other types of severe and chronic diseases. Another example is Medicaid coverage, which excludes long-term institutionalization for mental illness in specialty hospitals while providing coverage for similar hospitalizations for other illnesses.⁴ When the New York State Task Force on Life and the Law studied the need for surrogate decision-making for medical treatment for persons without capacity, it developed a set of recommendations to address this problem, while specifically excluding residents of mental health facilities.⁵

2. See *Taking Issue with Taking Issue: "Psychiatric Survivors" Reconsidered*, 48 PSYCHIATRIC SERVICES 601-05 (May 1997).

3. *Id.*

4. See 42 U.S.C.A. § 1396d(a)(1) (West Supp. 1997); see also 42 C.F.R. § 435.1008 (1997).

5. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE: DECIDING FOR PATIENTS WITHOUT CAPACITY at 174 (Mar. 1992).

The rules of law, custom, and practice that apply to most of the rest of medical practice and clinical care often do not apply to mental health care. In significant respects, persons institutionalized as mentally disabled live in a legal enclave, outside the effective protection of many laws that protect everyone else. There is a long tradition of regarding them in this fashion as illustrated by the following examples:

- The legal right that prisoners of war and convicted criminals have long enjoyed to outdoor fresh air and exercise⁶ has been routinely denied in some institutions for civilly committed mentally disabled patients across America. It has taken a recent lawsuit to gain some recognition of this right.⁷
- The enforcement of the Penal Laws rarely extends into institutions where thefts, assaults, and rapes routinely occur, and go unreported and uninvestigated.⁸ Even when reported within the institution, such crimes often go unprosecuted and unpunished.⁹

There is a culture of insularity and limited disclosure that seems to have permeated many if not most institutions. Notwithstanding a host of formal requirements for reporting events that occur within institutions (unusual incidents, medication errors, use of restraints or seclusion, etc.),¹⁰ there are few institutions unaffected by the problem

6. See, e.g., *Spain v. Procunier*, 600 F.2d 189, 199 (9th Cir. 1979); *Rhem v. Malcolm*, 371 F. Supp. 594, 627 (S.D.N.Y.), *aff'd*, 507 F.2d 333 (2d Cir. 1974); see also 7 N.Y. COMP. CODES R. & REGS. tit. 7, § 304.3 (1996) (providing for one hour of outdoor exercise daily for prisoners of the New York State Department of Correctional Services); *The Convention Relative to the Treatment of Prisoners of War* (July 27, 1929), reprinted in *THE LAWS OF ARMED CONFLICTS* 266 (Dietrich Schindler & Jiri Toman eds., 1973) (providing in Article 13 that prisoner of war camps "shall have facilities for engaging in physical exercises and obtaining the benefit of being out of doors").

7. See *Jean D. v. Cuomo*, No. 90 CIV. 0861 SS, 1993 WL 276067 at *1-2 (S.D.N.Y., July 20, 1993) (resolving a discovery dispute in which patients at mental hospitals alleged that procedures of the New York Department of Mental Health denied them access to fresh air).

8. See generally *Care of Institutionalized Mentally Disabled Persons: Joint Hearings Before the Subcomm. On the Handicapped of the Comm. On Labor and Human Resources and the Subcomm. On Labor, Health, and Human Services, Education and Related Agencies of the Comm. on Appropriations*, 99th Cong., 268-278 (1985) (testimony of Clarence J. Sundram) [Hereinafter *Joint Hearings*].

9. See generally NEW YORK STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, IN THE MATTER OF LISA COHEN: THE NEED FOR A POLICY IN THE DEVELOPMENTAL DISABILITIES SERVICE SYSTEM FOR REPORTING APPARENT CRIMES TO LAW ENFORCEMENT AGENCIES (Apr. 1987); NEW YORK STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, PATIENT ABUSE AND MISTREATMENT IN PSYCHIATRIC CENTERS: A POLICY FOR REPORTING APPARENT CRIMES TO AND RESPONSE BY LAW ENFORCEMENT AGENCIES (Dec. 1985).

10. See *Joint Hearings*, *supra* note 8, at 268.

of under reporting of such events.¹¹ It is not only that front line staff may not make the required disclosures to their superiors within the institutional hierarchy,¹² but also that supervisors can and do exercise discretion to classify reported events in a manner that exempts them from disclosure outside the institution.¹³ These tendencies exist to the greatest extent where the events at issue are likely to raise the most questions: for example, sexual encounters and assaults between patients.¹⁴

In this vein, when the New York State Office of Mental Health (OMH) negotiated a Multiple Project Assurance regarding research in its institutions, it exempted itself from reporting to federal oversight agencies the following: unanticipated problems involving risks to subjects or others; instances of serious or continuing noncompliance with federal regulations, requirements, or determinations of the IRB; and any suspension or termination of IRB approval for research.¹⁵ Instead, OMH substituted a requirement that, as a court later found, in effect had them reporting to themselves.¹⁶

The law of informed consent is just one more example of the different treatment of persons with mental illness. This is the only group of patients for whom informed consent to treatment is generally not required and whose assent to treatment is often assumed unless they specifically object. For instance, the New York Mental Hygiene Law requires "consent for surgery, shock treatment, major medical treatment in the nature of surgery, or the use of experimental drugs or procedures."¹⁷ Pointedly missing from this enumeration of procedures for which consent is required is psychiatric treatment with psychotropic medications. Moreover, it is interesting to note that we discuss the right to "informed consent" that patients have in the context of *medical care*. In contrast, in the context of *mental health treat-*

11. See *id.* at 272.

12. See *id.* at 273.

13. See *id.* at 275-76.

14. See Clarence J. Sundram, *Obstacles to Reducing Patient Abuse in Public Institutions*, 35 HOSP. & COMMUNITY PSYCHIATRY 238 (1984); see generally NEW YORK STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, SEXUALITY AND DEVELOPMENTAL DISABILITIES: AN INVESTIGATION OF SEXUAL INCIDENTS AT BERNARD FINESON DEVELOPMENTAL CENTER (Nov. 1991); NEW YORK STATE COMM'N ON QUALITY OF CARE FOR THE MENTALLY DISABLED, MANAGING RESOURCES IN THE MENTAL HYGIENE SYSTEM - THE INCIDENT REPORTING AND REVIEW SYSTEM: MORE PROCESS THAN IS DUE (Mar. 1983).

15. See *T.D. v. N.Y. State Office of Mental Health*, 650 N.Y.S.2d 173, 183 (N.Y.App. Div.1996), *appeal dismissed* by 680 N.E.2d 617 (N.Y. 1997), *leave to appeal granted* by 684 N.E.2d 281 (N.Y. 1997), and *appeal dismissed* by 1997 WL 785461 (N.Y. Dec. 22, 1997); see also 28 C.F.R. § 46.103 (b)(5) (1997) (federal reporting requirements).

16. See *T.D.*, 650 N.Y.S.2d at 183.

17. N.Y. MENTAL HYG. LAW § 33.03(b)(4) (McKinney 1996).

ment, we refer only to a "right to refuse" or a right to object rather than a right to informed consent. Until a recent ruling of the United States Supreme Court in the case of *Zinerman v. Burch*,¹⁸ it was common practice to accept the consent or acquiescence of a person in the throes of a psychotic episode for voluntary admission into a psychiatric facility without examining how "informed" or competent this decision was.¹⁹

The decades of accumulated experience and aculturalization of mental health professionals into this type of thinking and practice poses a formidable obstacle. This is especially true when it comes to extending these professionals' decision-making past the zone of normal psychiatric treatment and into the realm of experimentation, both therapeutic and non-therapeutic. The common practice in which treating clinicians take on an additional role as research investigators enhances these risks as it brings these attitudes and experiences into another realm where the issues are far different and the stakes for the patient may be far higher.²⁰ No wonder that many observers of the research process have described the researcher's mind-set as impatient with the fussy formalities of informed consent, and as regarding such "formalities" as hurdles to be overcome rather than requirements to be met.²¹ Furthermore, "the language used in a research

18. 494 U.S. 133 (1990).

19. See *id.* In *Zinerman*, the court held that a patient, committed voluntarily to a state institution in Florida when incompetent to give informed consent, was not precluded from asserting a claim that staff members of that institution denied patient procedural safeguards required by the Constitution for involuntary commitment of a mentally ill person. See *id.*

20. See Jay Katz, *Human Experimentation and Human Rights*, 38 ST. LOUIS U. L.J. 7, 12-18 (1993); see also Steve Stecklow & Laura Johannes, *Test Case: Drug Makers Relied on Clinical Researchers Who Now Await Trial; Two Professors Are Accused of Endangering Patients and Stealing \$10 Million*, THE WALL ST. J., August 15, 1977, at A1 (describing the pressures to recruit human subjects and the misleading information given to secure consent).

21. *Id.* Professor Katz characterizes the law of informed consent as a fairy tale myth. See generally, Jay Katz, *Informed Consent: A Fairy Tale? Laws Vision*, 39 U. PITT. L. REV. 137 (1977). The National Commission for the Protection of Human Subjects Biomedical and Behavioral Research in its *Report and Recommendations: Research Involving Those Institutionalized as Mentally Infirm*, reported "some investigators found the [IRB] review procedure to be an unwarranted intrusion on the investigator's autonomy . . . impeding the process of research." NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS BIOMEDICAL AND BEHAVIORAL RESEARCH, *REPORT AND RECOMMENDATIONS: RESEARCH INVOLVING THOSE INSTITUTIONALIZED AS MENTALLY INFIRM* 49-50 (DHEW Publication No. (OS) 78-0006, (1978)) (emphasis added); see also Paul R. Benson et al., *Informed Consent in Psychiatric Research: Preliminary Findings from an Ongoing Investigation*, 20 SOC. SCI. MED. 1331 (1985); Richard Delgado & Helen Leskovic, *Informed Consent in Human Experimentation: Bridging the Gap Between Ethical Thought and Current Practice*, 34 U.C.L.A. L. REV. 67, 104 (1986); Richard W. Garnett, *Why Informed Consent? Human Experimentation and the Ethics of Autonomy*, 36 CATH. LAW. 455, 476 (1996) ("the informed consent requirement is viewed as a chore and a

setting regularly slips into the language of clinical care, increasing the possibility that a potential subject may be confused."²²

It is not only the clinician-researcher's experience that compromises genuine informed consent to participation in research. Psychiatric inpatients are generally familiar with the limitations on their power of consent. If they have not had personal experience with being involuntarily committed to a psychiatric hospital, they have likely resided on wards with many others who are there involuntarily.²³ Patients who have attempted to exercise the recently recognized right to refuse treatment with psychotropic medications²⁴ have discovered that when the institution challenges their right, they lose in the overwhelming majority of cases.²⁵ Thus, psychiatric inpatients may not appreciate the distinction between treatment and research or that they have a more robust legal right to refuse the latter than the former. They may therefore have no reason to believe that their refusals to participate in research will be any more likely to be successful in avoiding the proposed intervention.

One other point must be considered in setting the context. While there are notable and recent exceptions, especially in the area of experimental treatment for cancer and AIDS, history is replete with examples of dangerous experiments being performed on people who are relatively powerless and vulnerable, a category into which institutionalized mentally disabled persons clearly fall.²⁶ Among the examples are the following:

ritual, an impersonal incantation, a hurried signing of papers . . . a subterfuge aimed more at easing our consciences than at protecting research subjects . . .").

22. Evan Gaines DeRenzo, *The Ethics of Involving Psychiatrically Impaired Persons in Research*, IRB, Nov.-Dec. 1994 at 7.

23. See Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, DHHS. unpublished provisional data, Inventory of Mental Health Organizations (IMHO) and General Hospital Mental Health Services conducted (1994) (unpublished provisional data, on file with the State of New York Commission on Quality of Care for the Mentally Disabled). According to the 1994 end of the year census for all 24-hour psychiatric hospital care settings, 43 percent of the 145,220 patients were on involuntary status. In state and county mental hospitals, 66 percent of the 69,200 patients were on involuntary status. See *id.*

24. See, e.g., *Washington v. Harper*, 494 U.S. 210 (1990); *Rogers v. Okin*, 821 F.2d 22 (1st Cir. 1987); *Rennie v. Klein*, 720 F.2d 266 (3d Cir. 1983); *Rivers v. Katz*, 495 N.E.2d 337 (N.Y. 1986).

25. See, e.g., J. Richard Ciccone et al., *Medication Refusal and Judicial Activism: A Reexamination of the Effects of the Rivers Decision*, 44 HOSP. & COMMUNITY PSYCHIATRY 555 (1993); William A. Hargreaves et al., *Effects of the Jamison-Farabee Consent Decree: Due Process Protection for the Involuntary Psychiatric Patients Treated with Psychoactive Medication*, 144 AM. J. PSYCHIATRY 2 (1987); Julie Magno Zito et al., *One Year Under Rivers: Drug Refusal in a New York State Psychiatric Facility*, 12 INT'L J.L. & PSYCHIATRY 295 (1989).

26. See Delgado & Leskovic, *supra* note 21, at 104.

- the deliberate infection of mentally retarded residents of the Willowbrook State School with live hepatitis virus, while researchers misinformed their parents that they were receiving vaccines²⁷ (In addition, consent to this experimentation was obtained from parents by conditioning admission to scarce institutional beds upon their consent.);²⁸
- radiation experiments involving adolescents in a Massachusetts institution for the mentally retarded whose parents were misinformed about the nature of the experiment;²⁹
- the research into malaria, dysentery and influenza during the second World War in which residents of institutions for the mentally ill and mentally retarded were frequently used as human subjects;³⁰
- the Tuskegee syphilis study in which hundreds of black men were allowed to languish with untreated syphilis, and were not informed of the nature of the study or the availability of treatment;³¹
- the Jewish Chronic Disease Hospital study in which researchers injected live cancer cells into unknowing and non-consenting patients who were dying of various chronic and debilitating diseases;³²
- the first lung transplant, whose recipient was John Russell, a prisoner serving a life sentence for murder who had serious lung problems.³³

27. See DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFERRED MEDICAL DECISION MAKING 77 (1991); see also Philip M. Bein, *Surrogate Consent and the Incompetent Subject*, 46 FOOD DRUG COSMETIC L.J. 739, 756 (1991).

28. See Bein, *supra* note 27, at 756.

29. See Advisory Committee on Human Radiation Experiments, Final Report 210-211 (1996).

30. See ROTHMAN, *supra* note 27, at 33-39.

31. See ROBERT J. LEVINE, ETHICS AND REGULATION OF CLINICAL RESEARCH 69-70 (2d ed. 1986).

32. See Garnett, *supra* note 21, at 465.

33. See *id.* at 482. Another example of research upon a prisoner which was proposed but never conducted because of a court order was described in *Kaimowitz v. Department of Mental Health for the State of Michigan*, No. 73-19434-AW (Cir. Ct. Wayne Co., Mich. July 10, 1973), reprinted in 1 MENTAL DISABILITY L. REP. 147 (1976). The prisoner, John Doe, had been committed to a state hospital as a sexual psychopath. See *id.* at 147. He signed an informed consent for psychosurgery, as did his parents, for a research study of uncontrollable aggression. See *id.* The research was designed to compare the effects on male hormone flow of a psychosurgical procedure with those of a particular drug. See *id.* Although both a scientific review committee and a human rights review committee reviewed and approved the proposed experiment, the court blocked it, stating, "Psychosurgery should never be

- the first chimpanzee heart transplant, whose recipient was Boyd Rush, a poor deaf mute man who did not consent to the transplant when he arrived at the hospital unconscious and dying;³⁴
- a chimpanzee kidney transplant performed on Jefferson Davis, a poor black man, who agreed after doctors told him he would die otherwise;³⁵
- an experimental baboon heart transplant performed on "Baby Fae," a poor and dying child, with her mother's consent.³⁶

When the National Commission for the Protection of Human Subjects of Biomedical and Behavior Research issued its consensus statement in 1979 on the ethical principles governing human experimentation (commonly referred to as the Belmont Report),³⁷ it identified three ethical principles: respect for persons, beneficence, and justice.³⁸ With respect to justice, the principle requires that the benefits and burdens of research are fairly distributed among groups and individuals.³⁹ In essence, the Commission stated that the burden of research should not fall unduly upon relatively disadvantaged groups, while the benefits that flow from the research accrue to those who are in a more economically and politically advantageous position.⁴⁰ According to the Code of Medical Ethics of the American College of Physicians, "[T]he over-use of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participant is subjected to powerful incentives and

undertaken upon involuntarily committed populations, when there is a high-risk low-benefits ratio as demonstrated in this case. This is because of the impossibility of obtaining truly informed consent from such populations" See *id.* at 148.

34. See GEORGE J. ANNAS ET AL., INFORMED CONSENT TO HUMAN EXPERIMENTATION: THE SUBJECT'S DILEMMA 15-16 (1977).

35. See *id.* at 15.

36. See George J. Annas, *Baby Fae: The "Anything Goes" School of Human Experimentation*, in JUDGING MEDICINE 385, 389 (1988). For a review of other experiments of questionable scientific or ethical value, see Henry Beecher, *Ethics and Clinical Research*, 274 NEW ENG. J. MED. 1354 (June 16, 1966).

37. NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR PROTECTION OF HUMAN SUBJECTS OF RESEARCH (DHEW Publication No. (OS) 78-0012, 1979).

38. See *id.* at 4.

39. See *id.* at 8-10.

40. See Rebecca Dresser, *Mentally Disabled Research Subjects: The Enduring Policy Issues*, 276 JAMA 67, 71 (July 3, 1996).

persuasion."⁴¹ In institutions it does not take much for an inducement to be powerful. The adolescents at the Fernald State School for the Mentally Retarded in Massachusetts, who were recruited to participate in nontherapeutic experiments involving the ingestion of radioactive iron, calcium and iodine, were offered a quart of milk daily, trips to baseball games and the beach, and outside dinners.⁴² As one of them later told the Advisory Committee on Human Radiation Experiments (ACHRE), "They bribed us by offering us special privileges, knowing that we had so little that we would do practically anything for attention"⁴³

In the context of research protection, the widespread view in the research community apparently was that the American Medical Association's Statement of Principle of 1946 regarding voluntary consent of research subjects,⁴⁴ the Nuremberg Code of 1947,⁴⁵ the Declaration of Helsinki adopted by the World Medical Assembly in 1964 and subsequently revised in 1975 and 1983,⁴⁶ the International Covenant on

41. *Principles of Medical Ethics and Current Opinions of the Council on Ethical Affairs*, in CODES OF PROFESSIONAL RESPONSIBILITY 189, 195 (Rena A. Gorlin ed., 2nd ed., 1991).

42. See ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS, *supra* note 29, at 210-11.

43. *Id.*, at 210; see also, American College of Physicians, *Cognitively Impaired Subjects*, in 3 ANNALS INTERNAL MEDICINE, 843, 846 (1989) (concluding that institutionalized patients may be more susceptible to positive inducements to give consent, such as a change in living quarters).

44. See *Supplementary Report of the Judicial Council in Proceedings of the House of Delegates Annual Meeting*, Dec. 9-11, reprinted in 132 JAMA 1090 (1946). The council found that in order for the Principles of Medical Ethics to conform to the ethics of the American Medical Association three requirements must be satisfied: (1) the consent of the person on whom the experiment is being performed must be voluntary; (2) "the danger of each experiment must be previously investigated by animal experimentation, and (3) the experiment must be performed under proper medical protection and management." *Id.* at 1090.

45. See Jay Katz, *The Consent Principle of the Nuremberg Code: Its Significance Then and Now*, in THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION at 2 (George J. Annas & Michael A. Grodin eds., 1992). The first principle in the Nuremberg Code reads:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other alternative form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

Id. at 2.

46. See WORLD MEDICAL ASSOCIATION, *Declaration of Helsinki*, in THE ETHICS OF RESEARCH INVOLVING HUMAN SUBJECTS — FACING THE 21ST CENTURY 433 (Harold Y. Vanderpool ed., 1996).

Civil and Political Rights,⁴⁷ despite their clear language, could not have meant to preclude the use of mentally incompetent patients in experiments, both therapeutic and nontherapeutic. Thus, respected researchers in respected institutions continued to perform experiments at high levels of risk upon persons with mental impairments, without any consent at all, and to publish their findings and methods in respected journals with impunity.⁴⁸

Even during the recent surge of interest in the protection of vulnerable populations in human subject research, the institutionalized mentally disabled population once again has been excluded from any special safeguards. In 1978, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research recommended special protections for the institutionalized mentally infirm.⁴⁹ While the Department of Health, Education and Welfare (DHEW), the predecessor agency to the current Department of Health and Human Services (HHS), published proposed regulations,⁵⁰ the regulations were never finalized.

In 1981 and again in 1983, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research urged the promulgation of final regulations to address this subject.⁵¹ However, the Secretary of HHS declined to do so, reportedly due to a lack of consensus on the need for them as well as the alleged adequacy of existing regulations.⁵² Most recently, the Advisory Committee on Human Radiation Experiments endorsed the need for guidelines protecting institutionalized adults of questionable competence in human subject research.⁵³ At present, the federal regulations governing human subject research⁵⁴ have special safeguards for children,⁵⁵ pregnant women,⁵⁶ and prisoners.⁵⁷ However, despite

47. See G.A. Res. 2200A (XXI), U.N. GAOR, Supp. No. 16, at 52, U.N. Doc. A/6316 (1966). Article 7 states: "No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation." *Id.*

48. See, e.g., Leonard S. Rubenstein, *Psychiatric Experimentation: The Lessons of History*, 5 J. CAL. ALLIANCE FOR MENTALLY ILL 22, 24 (1994).

49. THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 21.

50. See 43 Fed. Reg. 53,950-56 (1978).

51. See Robert J. Levine, *Proposed Regulations for Research Involving Those Institutionalized as Mentally Infirm: A Consideration of Their Relevance in 1996*, IRB, Sept.-Oct. 1996, at 1.

52. See *id.*

53. See ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS, *supra* note 29, at 226, n.96 (1996).

54. See generally Protection of Human Subjects, 45 C.F.R. § 46 (1997).

55. See *id.* §§ 46.407-409.

56. See *id.* §§ 46.205-207.

repeated recommendations from each of the blue ribbon panels appointed to consider these issues,⁵⁸ at present convicted criminals have better recognition in law of their special vulnerability in human subject research due to institutionalization than do institutionalized mentally disabled persons who carry the additional likelihood of cognitive impairments. In research, as in many other areas of life, institutionalized mentally disabled individuals are once again in a class by themselves and disadvantaged by that classification.

When laws and regulations *do* address the rights and interests of mentally disabled persons, there is often a prolonged period of simply disregarding whatever it is in these requirements that is inconvenient. There are numerous examples of this pattern of behavior including disregard for laws dealing with requirements for individualized treatment plans, for patient and family participation in treatment planning, and for discharge planning.⁵⁹ As Erving Goffman recognized, there is a wide gulf between the formal life of an institution, which is replete with rules, regulations, policies and procedures, and the underlife or real life of an institution, which is governed largely by the demands of convenience.⁶⁰

Faced with a mental health professionals' failure to comply with the laws, mentally disabled persons have a limited ability to advocate for themselves.⁶¹ Their mental impairment also places a cloud upon their credibility and leads to a discounting of the value of what they say when they allege violations of law. The most vulnerable are the seriously and persistently mentally ill who are often disconnected from any family or community support system. The nature of their illnesses and their life experiences often alienate them from others who may be natural allies, especially their families. Other advocates, including those provided by the Protection and Advocacy Program,⁶²

57. See *id.* §§ 46.304-306.

58. See *supra* notes 51-53 and accompanying text.

59. See, e.g., N.Y. MENTAL HYG. LAW §§ 29.15(f) & (g), 33.02(a)(11) (McKinney 1996); see also *Heard v. Cuomo*, 594 N.Y.S.2d 675 (1993) (Homeless and mentally ill persons successfully sued the state of New York to enforce the state's obligation to take steps to ensure adequate and appropriate housing is provided upon discharge from the institution.); see generally DAVID J. ROTHMAN, *CONSCIENCE AND CONVENIENCE: THE ASYLUM AND ITS ALTERNATIVES IN PROGRESSIVE AMERICA* (1980).

60. See generally Erving Goffman, *Asylums* (1962).

61. See *Joint Hearings*, *supra* note 8, at 1. According to Senator Lowell Weiker Jr., Chairman of the United States Subcommittee on the Handicapped "Protection for these frailest of our society exists largely on paper." *Id.*

62. See Clarence J. Sundram, *Implementation and Activities of the Protection and Advocacy Program for Persons with Mental Illness*, 48 *PSYCHIATRIC SERVICES* 702 (1995); see generally 42 U.S.C. §§ 10-801 *et seq.* (implementing the Protection and Advocacy Program for mentally ill individuals).

are in short supply and often experience inordinate difficulty in simply gaining access to facilities and reliable information.⁶³ The enforcement of their rights and of the laws enacted for their protection is therefore fraught with difficulty.

All of this context is relevant to thinking about the role of formal structures like laws and regulations as a solution to whatever problems currently exist and to the abuses that have been uncovered.⁶⁴ Any solutions are unlikely to be self-executing and are unlikely to be respected and obeyed unless there is seachange in attitudes towards persons with serious mental illness. The history of reforms in mental health systems shows that accountability comes slowly and only after a prolonged public spotlight on the habits of the underlife, usually coupled with pressure from the legislative or judicial branches of government. Reliance upon professionals alone for change will not suffice. The strong resistance that has been demonstrated to the reforms proposed in the recent past by Presidential Commissions and to proposed regulatory reforms indicates how strongly the research community disagrees with the very need for reform, and how difficult it will be to implement any new formalities.⁶⁵

III. CURRENT PRACTICE

The history of what has transpired since the responsibility for policing research was given to the relatively invisible institutional review boards (IRBs) and to a relatively invisible process is instructive.⁶⁶

63. See *Alabama Disabilities Advocacy Program v. J.S. Tarwater Developmental Center*, 97 F.3d 492 (11th Cir. 1996) (suing to gain access to records of residents who had died while they were in the facility); *Mississippi Protection and Advocacy System v. Cotten*, 929 F.2d 1054 (5th Cir. 1991) (suing to gain access to patients residing therein); *Robbins v. Budke*, 739 F. Supp. 1479 (D. N.M. 1990) (suing to receive greater access to patient records); *Maryland Disability Law Center v. Mt. Washington Pediatric Hospital, Inc.*, 666 A.2d 16 (Md. Ct. Spec. App. 1995) (suing to gain access to hospital records for the purpose of abuse and neglect investigation).

64. See Philip J. Hils, *Agency Faults a UCLA Study for Suffering Mental Patients*, N.Y. TIMES, Mar. 10, 1994, at A1, A11. The Office of Protection from Research Risks ruled that UCLA failed to get proper consent from schizophrenic patients in an experiment in which they were taken off medications and allowed to suffer severe losses. See *id.*

65. See Garnett, *supra* note 21, at 48. ("If we need to perform the experiment in a difficult case, we will. If necessary, we proceed without consent or with only a perfunctory acquiescence, which may reflect desperation, resignation, or simply confusion, but certainly not a robust commitment to human dignity and autonomy."). See also NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS IN BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 22, at 113-20.

66. See Evan DeRenzo, *Surrogate Decision-Making for Severely Cognitively Impaired Research Subjects: The Continuing Debate*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 539, 545 (1994) ("Problems in the present review system of narrowness, isolated discussions, and having to

There is of course a clash of competing interests here. On one hand, there is a strong interest in learning more about disease, illness, and cures, an interest that is shared by researcher, subject, and family. The urgency with which this interest is shared probably varies among these groups with the immediacy of the prospect of direct benefit. On the other hand is the protection of the health, safety, and welfare of the subject, an interest perhaps felt most keenly by the research subject himself.

In dealing with this clash of interests, the law has called for a balancing of risks and benefits.⁶⁷ However, the balance struck has been an imperfect one. This is in part because those with a lot at stake, the research subjects and their families, have not had much voice or access in either articulating the interests at issue or in striking the balance. It is interesting to note that when different groups are asked to identify people to protect the rights of the decisionally impaired, they select different people. For example, federal regulations require that "[i]f an IRB regularly reviews research that involves a vulnerable category of subjects, such as . . . mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects."⁶⁸ This may be interpreted to mean that IRBs should include one or more psychiatrists, ethicists, and lawyers. However, family members are more likely to see the value of other families in this capacity.⁶⁹ Nevertheless, primary consumers have been unusually silent on the issues involved in research using human subjects. This is perhaps because more pressing issues of day-to-day existence consume their energies. It is also perhaps because most of this discussion has taken place in professional journals and other fora that are not readily accessible to them.

Despite the feeble attempt to bring in an outside perspective to the process of review, these balancing judgments are made by the researchers in the first instance and by the IRBs in their reviewing capacity. Thus, such judgments have usually been made through a process that is inaccessible to and unreviewable by the interested

reinvent the wheel were identified in the recommendations of the Tuskegee Syphilis Study Ad Hoc Advisory Panel and are as relevant now as they were 20 years ago.").

67. See generally Protection of Human Subjects, 45 C.F.R. § 46 (1997).

68. *Id.* § 46.107(a).

69. See Adil E. Shamoo & Diane N. Irving, *Accountability in Research Using People with Mental Illness*, 3 ACCOUNTABILITY RES. 1, 9 (1993).

stakeholders. Neither process of review has proved to be a reliable safeguard.⁷⁰

In theory, there is a detailed and formidable multi-level process of review and safeguards. In practice, however, there are many gaps and weaknesses in this system including the following:

- (1) the inability of IRBs to meet all the expectations placed upon them;
- (2) the general absence of direct monitoring of research practices;
- (3) the limited role actually played by federal oversight agencies given the complexity and volume of research involved; and
- (4) the substantial volume of research that lies outside the reach of federal regulations.

A. *Inability of IRBs to Meet Expectations*

In 1996, the General Accounting Office (GAO) reviewed federal oversight systems for protecting human subjects in federally sponsored scientific experiments.⁷¹ The GAO concluded that the oversight procedures are impaired by the workload of the IRBs and the competing demands upon the time of the unpaid IRB members, coupled with the sheer number of studies, which necessitates that IRBs spend only a few minutes of review per study.⁷² There were reported instances of IRBs reviewing 100-150, and sometimes as many as 200, proposals and ongoing studies in a single meeting.⁷³

Additionally, the GAO found the IRBs' conduct of continuing reviews were typically either superficial or not done at all.⁷⁴ The heavy workload requires that IRBs rely largely on investigators' self-assessments in conducting these continuing reviews, creating a risk of selective reporting of favorable results and withholding information about

70. See generally Douglas K. Martin et al., *The Incommensurability of Research Risks and Benefits: Practical Help for Research Ethics Committees*, IRB, Mar.-Apr. 1995, at 8; Eric M. Meslin, *Protecting Human Subjects from Harm Through Improved Risk Judgments*, IRB, Jan.-Feb. 1990, at 7, 8; Peter C. Williams, *Success In Spite of Failure: Why IRBs Fail in Reviewing Risks and Benefits*, IRB, May-June 1984, at 1.

71. GENERAL ACCOUNTING OFFICE, SCIENTIFIC RESEARCH: CONTINUED VIGILANCE CRITICAL TO PROTECTING HUMAN SUBJECTS, REPORT NO. HEHS-96-72 (Mar. 8, 1996) [hereinafter GAO REPORT].

72. See *id.* at 17-19.

73. See *id.* at 17.

74. See *id.*

deviations from the study protocol.⁷⁵ Other concerns raised by the GAO include the lack of independence, and collegial and institutional pressures upon IRB members that cloud their role as a safeguard on research practices.⁷⁶

Over the years, the New York State Commission on Quality of Care has monitored institutions and responded to complaints regarding research at large state-operated psychiatric centers affiliated with respected medical schools and hospitals in New York State. In the process the Commission has seen evidence to confirm the GAO's overall finding and conclusion that, while there is on paper a multi-level process of review and safeguards for human subjects involved in research, the actual implementation of these processes renders the safeguards illusory when they are most needed, specifically, when researchers may not be committed to a rigorous adherence to the letter and spirit of the law, or may be inclined to cut corners. Additionally, IRBs often fail to diligently review initial protocols as illustrated by the following examples.

1. IRB's improperly approved some protocols. New York State regulations mandate that patients who are deemed "incapable" may only be placed in non-therapeutic experiments when such experiments "could not be carried out without the involvement of incapable subjects."⁷⁷ This provision is apparently intended to strictly limit the potential use of incapable patients in research, and all the attendant legal and ethical problems posed by such research. However, after three research protocols were approved for using incapable subjects in non-therapeutic experiments, some or all of the patients actually enrolled in the research were capable subjects.⁷⁸ This suggests that (1) the researcher initially overstated the case justifying research upon incapable subjects, (2) the IRB was insufficiently thorough in its scrutiny of this asserted rationale, (3) the researcher departed from the protocol, and (4) the IRB failed to adequately monitor the implementation of this protocol which was done in a manner inconsistent with the original justification.

2. IRBs approved protocols with consent forms which omitted significant information concerning the research procedures. In one study involving ECT and mania, the consent form did not disclose that

75. See *id.* at 17-18.

76. See *id.* at 18.

77. N.Y. COMP. CODES R. & REGS. tit. 14, § 527.10(d)(6) (1996).

78. See Lowenkron Affidavit, Exhibit W, Sworn to Sept. 9, 1992, Record on Appeal at 2554, T.D. v. New York State Office of Mental Health, 650 N.Y.S.2d 173 (1996) (No. 5136/91).

there would be a withdrawal from medication for 4-7 days with a 7-10 day washout period before starting ECT.⁷⁹ In another cerebral blood flow study, the consent form did not disclose that measurements would be taken during an 8-12 week period during which the patient would be withdrawn from medications.⁸⁰ In a dopamine agonist study, patients were not informed of the risk of Neuroleptic Malignant Syndrome or the irreversibility of Tardive Dyskinesia as possible side effects of the neuroleptic medications which were administered as part of the research protocol.⁸¹ A common side effect of the medication Sinemet — involuntary movements — was also not included on the consent form.⁸² Patients in this study were also not informed that taking Sinemet without a neuroleptic might cause an exacerbation of psychiatric symptoms.⁸³ Such information would appear relevant in a patient population that often fails to take prescribed neuroleptic medications.⁸⁴

Beyond the lack of disclosure of the specific risks entailed in a particular research protocol, there are more generic risks and harms that could significantly affect the welfare of patients. Such risks and harms are rarely ever discussed or disclosed, or required by IRBs to be discussed or disclosed. First, drug washouts can and do cause relapse in some mentally ill patients. One report indicates an overall relapse rate of 54.8% for patients taken off medications during an average follow-up period of 9.7 months, compared to a 16.6% relapse rate for patients maintained on medications.⁸⁵ Even in the first three months without medication, the relapse rate is 44%.⁸⁶ The abrupt discontinuation of medications, which occurs in many research protocols, induces a threefold greater risk of relapse than gradual discontinuation over a period of weeks and months.⁸⁷ The likelihood of harm to the human subject under these circumstances not only raises a question

79. See New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings at 6 (May 28, 1987) (on file with author).

80. See *id.*

81. See New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings at 6 (Nov. 9, 1994) (on file with author).

82. See *id.*

83. See *id.*

84. See *id.*

85. See Paul S. Appelbaum, *Drug-free Research in Schizophrenia: An Overview of the Controversy*, IRB, Jan.-Feb. 1996, at 1, 3.

86. See *id.* at 3.

87. See *id.*

of disclosure, but also implicates provisions of both the Nuremberg Code and the Declaration of Helsinki.⁸⁸

Second, after multiple psychotic episodes, there is a possibility that there will remain residual impairments or a so-called "toxic" effect which increases the likelihood of further episodes in the future and decreases the long-term effect of existing medications.⁸⁹ Each such episode may damage the individual irreparably to some extent. How does one assess or value the wear and tear on family and other relationships that occur during such episodes? How does the researcher or IRB know which episode might be the straw that breaks the proverbial camel's back and irreparably severs relationships? People with serious mental illness live in a fragile world of unreliable and often inaccessible services and uncertain supports. Informed consent means weighing not only the short-term risks of suicide attempts or violence, but also the long-term impact on family and other relationships, on estrangement, alienation, and the loss of perhaps the only reliable safety net for the seriously mentally ill person. The patient himself is in the best position to assess the severity of these risks, aided by others involved in his life. But, without clear disclosure of the risks and conscious evaluation, how does the patient make an intelligent assessment?

We need to recognize that people with serious mental illness can decompensate rapidly and lose everything in a very short period of time. And some of these losses can be irreparable. Indeed, if the drug washout and ensuing relapse are severe enough, the researcher may have no choice but to remove the subject from the study. In a world of scarce resources and multiple and competing demands, people who

88. See Nuremberg Code, *reprinted in* KATZ, *supra* note 45, at 2. Principles 5 and 10 of the Nuremberg Code provide that:

- 5.) No experiment should be conducted where there is an a priori reason to believe that death or disabling will occur; except, perhaps in those experiments where the experimental physicians also serve as subjects.
- 10.) During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.

Id.; see also Declaration of Helsinki, *reprinted in* WORLD MEDICAL ASSOCIATION, *supra* note 46, at 436. Section III of the Declaration of Helsinki provides in pertinent part that "(3) The investigator or the investigating team should discontinue the research if in his/her judgment it may, if continued, be harmful to the individual; [and] (4) In research on man, the interest of science and society should never take precedence over considerations related to the well-being of the subject." *Id.*

89. R.J. Wyatt, *Risks of Withdrawing Antipsychotic Medications*, 17 SCHIZOPHRENIA BULL. 375 (1991).

develop severe reputations for violent psychotic behavior are disadvantaged in competing for access to services, especially in the community. They may thus have to endure prolonged institutionalization.

In seeking informed consent, researchers and IRBs need to be mindful that, for both patients and families, submission to research may be viewed as a means of obtaining access to better care than their financial circumstances would otherwise allow. This is a factor that is likely to play an increasingly prominent role as managed care and the rationing of services continues to take hold in the mental health service system. With these motivations as possibilities, it is particularly important to disclose to the patient that his individual care will be subordinated to the necessary rigidity of a research protocol. Additionally the patient needs to be informed of the possibility that he may be admitted to a research protocol but placed in a control group where he receives no treatment at all. If this is the case, what is the specific benefit being offered to the patient? It is vitally important to address this "therapeutic illusion" that many patients have about research, regardless of what is said to them, especially if their consent is obtained by the treating clinician in his capacity as researcher.⁹⁰

The Advisory Committee on Human Radiation Experiments conducted a Subject Interview Study (SIS) of over 1,800 research subjects and concluded:

One of the most powerful themes to emerge from the SIS is the role of trust in patients' decisions to participate in research. . . . [T]hey trusted that their physicians would never endorse options that were not in their best interests. This trust underscores the tension in the role of physician-investigator, whose duties as a healer and as a scientist inherently conflict.⁹¹

In research that exposes patients to more than minimal risk, the safeguards for research subjects with decisional impairments should include capacity assessments by qualified clinicians unaffiliated with the researcher or the institution, and the disclosure of risks and benefits should be likewise made or supplemented by an independent educator.

90. Paul S. Appelbaum et al., *False Hopes and Best Data: Consent to Research and Therapeutic Misconception*, 2 HASTINGS CENTER REP. 2, 20 (1987).

91. Advisory Committee on Human Radiation, *Research Ethics and the Medical Profession: Report of the Advisory Committee on Human Radiation Experiments*, 276 JAMA 403, 408 (1996).

B. Absence of Direct Monitoring by the IRB of the Research Being Conducted

1. In some instances, the Commission found that researchers themselves were making the determination of whether patients had the capacity to consent to participation in the research protocol. Given the pressures that researchers are under to recruit subjects for their research,⁹² and the additional layers of scrutiny that are triggered when a potential subject is determined not competent to consent,⁹³ permitting researchers to play this role exposes patients to unnecessary risks of improper or questionable determinations of capacity to consent to participation. As sometimes occurs in other areas,⁹⁴ there appears to be a tendency to use a lower threshold of competence for patients who agree on a course of action that a clinician sees as desirable, than for patients who disagree.

2. In several cases reviewed by the Commission over the years, there was insufficient evidence in the record to support a finding of capacity to consent in the face of other documentary information which raised substantial questions about the patient's level of functioning. For example, in the case of a patient who was found to be capable of consenting to a dopamine agonist study, progress notes during the neuropsychological testing, which was a component of the study, indicated that the patient was "floridly hallucinating and delusional."⁹⁵ A few days later a social worker's note described the patient as "unkempt and disheveled and not able to attend vocational programming," concluding that the patient remains actively psychotic and "paces the day hall almost continually, seemingly absorbed in internal stimuli."⁹⁶

At another institution, although the research protocol for the study expressly excluded patients without sufficient mental capacity to give informed consent, an examination of five cases chosen randomly revealed that in two, the treating psychiatrist expressed the opinion

92. See Stecklow & Johannes, *supra* note 20 (describing the financial pressures to recruit human subjects).

93. See, e.g., Protection of Human Subjects, 45 C.F.R. §§ 46.111(b), 46.116(e) (1997); N.Y. COMP. CODES R. & REGS. Tit. 14, §§ 527.10(e)(2), 633.13(a)(3) (1996).

94. See generally Charles E. Schwartz, *Medical Decision-Making for People with Chronic Mental Impairments*, in CHOICE & RESPONSIBILITY: LEGAL AND ETHICAL DILEMMAS IN SERVICES FOR PERSONS WITH MENTAL DISABILITIES 135 (Clarence J. Sundram ed., 1994); Bruce J. Winick, *Competency to Consent to Treatment: The Distinction Between Assent and Objection*, 28 Hous. L. Rev. 15 (1991).

95. New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings 3 (Nov. 9, 1994) (on file with author).

96. *Id.*

that the patient was incapable of understanding the contents of the consent form.⁹⁷ Yet, both patients were included in the research without further explanation.⁹⁸

There seems to be a view that it is appropriate for researchers to rely upon the general presumption of competence, absent a judicial finding of incompetence.⁹⁹ In my view, this is a misplaced reliance upon a misunderstood legal concept. Presumptions of competence are useful in general when one has no information that might suggest anything to the contrary. However, when dealing with a population of seriously mentally ill individuals, some of whom have been admitted to psychiatric facilities involuntarily, and many of whom suffer from some degree of cognitive impairment, there is a clear duty to conduct a further patient-specific inquiry about decision-making capacity rather than relying upon a general presumption of competence alone. The Supreme Court's ruling in *Zinermon v. Burch* points to the hazards of relying upon a presumption alone when the circumstances place the clinician on notice of a duty of further inquiry.¹⁰⁰

3. Informed consent documents were approved by the IRB in an ECT study.¹⁰¹ However, the consent forms actually used by the researchers differed from the approved version.¹⁰² In another instance, the printed consent forms were largely illegible and confusingly worded.¹⁰³

4. The IRB's lack of on-going review of the implementation of the research protocols left patients who were not doing well on the research protocol without adequate oversight protection. For exam-

97. See New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings 5 (May 28, 1987) (on file with author).

98. See *id.*

99. Remarks of Dr. John Oldham, Senior Medical Officer of the New York State Office of Mental Health, *Conducting Medical Research on the Decisionally Impaired*, conference at the University of Maryland School of Law (May 28, 1997) (An article based on Dr. Oldham's remarks is included in this issue of *The Journal of Health Care Law & Policy*).

100. *Zinermon v. Burch*, 494 U.S. 133, 133 (1990) ("Indeed, the very nature of mental illness makes it foreseeable that a person needing mental health care will be unable to understand any proffered 'explanation and disclosure of the subject matter' of the forms that a person is asked to sign, and will be unable 'to make a knowing and willful decision' whether to consent to admission.").

101. See New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings 5 (May 28, 1987) (on file with author).

102. See *id.*

103. See THE NATIONAL COMMISSION FOR THE PROTECTION OF HUMAN SUBJECTS IN BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 22, at 48-49. The National Commission reported that only 5 percent of the informed consent forms from institutions for the mentally infirm that it reviewed were complete or nearly complete. It found that consent forms "tended to be difficult to read. The 'reading-ease' of most of the consent forms was comparable to that found in scholarly, academic material." *Id.*

ple, following the withdrawal of all medications as called for in one research protocol, a patient lost 27 pounds.¹⁰⁴ Although the patient's food intake was ordered to be closely monitored and fluids to be forced, medications continued to be withheld for another three weeks.¹⁰⁵ Another patient, approaching discharge at the time he entered the research program, suffered severe decompensation following removal from his medications and remained in the hospital an additional 15 months.¹⁰⁶

In a study of the treatment of young children with Downs Syndrome with recombinant DNA, the IRB approved two research protocols.¹⁰⁷ However, it performed no further monitoring of the implementation of the research.¹⁰⁸ In the implementation phase, the researchers substantially departed from the protocol and informed consent requirements. Some of the deviations follow:

- Twenty-four of the 31 children enrolled in the study were not eligible based on the Growth hormone responses recorded in their charts;¹⁰⁹
- None of the eligible participants had proper informed consents;¹¹⁰
- Participants were not randomly assigned to treatment or control groups;¹¹¹
- The informed consent document downplayed the effects of the growth hormone on development, misled parents by purporting to diagnose whether their children had growth hormone deficiency, and also did not disclose the experimental nature of the treatment or the risk of leukemia;¹¹²
- The failure to assign children to a control group and the inclusion of ineligible individuals into the study destroyed any potential validity of the study, completely ne-

104. See New York State Commission on Quality of Care for the Mentally Disabled, Letter of Findings 4 (May 28, 1987) (on file with author).

105. See *id.*

106. See *id.*

107. See THE INSTITUTE OF BASIC RESEARCH INSTITUTIONAL REVIEW BOARD AUDIT OF IRB APPLICATIONS 91-88, 92-128 AND 93-177: TREATMENT OF DOWN SYNDROME WITH RECOMBINANT HUMAN GROWTH HORMONE 2-4 (Nov. 14, 1994).

108. See *id.*

109. See *id.* at 9.

110. See *id.* at 13.

111. See *id.* at 15.

112. See *id.* at 5.

gating the possibility of any benefits from the research to offset the risks to which the children were exposed.¹¹³

None of these substantial departures from the approved protocol and the signed assurances to the IRB were detected until after an editorial was published in a professional journal.¹¹⁴

5. There is also a lack of reporting on research activities. When the New York Commission on Quality of Care for the Mentally Disabled reviewed one institution's IRB, there were no monthly or annual reports found for any of the protocols the commission reviewed.¹¹⁵ Furthermore, the minutes of their meetings were so brief as to be entirely uninformative about the substance of discussions.¹¹⁶ Thus, there was no ready means of reviewing the work of the IRB in carrying out its important responsibilities.

The point is not simply that IRBs are not monitoring the performance of research they have approved. The GAO report makes a persuasive argument about the impossibility of such a role for the IRBs as presently constituted.¹¹⁷ Indeed, given the composition of the IRBs, such a role may well be impossible, as well as undesirable, as an independent check on the conduct of research involving human subjects.¹¹⁸ The larger point, however, is that no one actually monitors the performance of research. There seems to be an elaborate procedural minuet which creates an illusion of careful safeguards and protection. However, there is often little behind this facade but the integrity of the researcher which remains the cornerstone of protection for the human subject. But as history has revealed time and again, by itself, this is not a reliable foundation upon which to erect an edifice of protection for the most vulnerable of human subjects.

C. *Limited Federal Oversight*

These weaknesses of the IRBs are compounded by the absence of a meaningful role by federal oversight agencies over the actual conduct of research. The GAO reported that "little data exists that di-

113. *See id.* at 17.

114. *See id.* at 6.

115. New York Commission on Quality of Care for the Mentally Disabled, Letter of Findings, at 4 (May 28, 1987) (on file with author).

116. *See id.* at 4-5 ("In some instances, the IRB minutes were so terse and non-descriptive that it was impossible to know whether it truly met its legal mandate beyond approving the initial protocols.").

117. *See supra* notes 71-76 and accompanying text.

118. *See generally* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SUMMING UP: THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH (Mar. 1983).

rectly measures the effectiveness of human subject protection regulations."¹¹⁹ Indeed, it appears that there is no single place in the oversight scheme that keeps track of how much research involving human subjects is actually being performed, the types of such research, or the extent to which they involve incapable subjects.¹²⁰

No data exist on the exact number of IRBs in the country, but estimates range from 3,000 to 5,000.¹²¹ The GAO reported that HHS has an annual five billion dollar investment through about 16,000 awards involving human subject research.¹²² HHS carries out its oversight functions through the Office for Protection of Research Risks (OPRR) and the Center for Drug Evaluation and Research (CDER) in the Food and Drug Administration.¹²³ Only 14 full-time employees in OPRR are responsible for overseeing protections in these 16,000 research awards.¹²⁴ At CDER, the FDA has allocated six full-time equivalent positions to the Division of Scientific Investigations for the oversight of IRB inspections.¹²⁵

D. Research That Lies Outside The Federal Regulations

Finally, there are gaps in the regulatory scheme between what is covered by federal regulation and what is left to state regulation. The Common Rule applies to research "conducted, supported or otherwise subject to regulation by any Federal Department or Agency which takes appropriate administrative action to make policy applicable to such research."¹²⁶ It does not affect state or local laws or regulations which may otherwise be applicable and which provide additional protections for human subjects.¹²⁷ These federal regulations depend upon state laws, for example, to define who may be "legally authorized" to consent to research on behalf of a prospective human subject.¹²⁸ State laws, such as Article 24-A of the New York Public Health

119. GAO REPORT, *supra* note 71, at 2.

120. Conversation by Kathryn McKee, Ph.D., with Dr. Andrea Baruchin, Associate Director for Science Policy, Office of Science Policy and Programming Planning, National Institute of Mental Health (Apr. 9, 1997); *see also*, Sheryl Gay Stolberg, "Unchecked" Experiments on People Raise Concern, N.Y. TIMES, May 14, 1997, at A1 (quoting R. Alto Charo of the President's National Bioethics Advisory Commission, who said "[w]e have better information about animal experiments than we do about human experiments").

121. *See* GAO Report, *supra* note 71, at 6.

122. *See id.* at 2.

123. *See id.*

124. *See id.* at 6.

125. *See id.*

126. Protection of Human Subjects, C.F.R. § 46.101(a) (1997).

127. *See id.* § 46.101(f).

128. *Id.* § 46.102(c).

Law, do not apply "to the conduct of human research which is subject to, and which is in compliance with, policies and regulations promulgated by any agency of the federal government for the protection of human subjects."¹²⁹ But, to be in compliance with federal policies and regulations, research must also comply with state law in obtaining consent from a legally authorized representative.¹³⁰ New York State law has an additional requirement that, in relation to the conduct of human research involving minors, incompetent persons, mentally disabled persons, and prisoners, the Commissioner of Health must consent to the research.¹³¹

This complex web of laws, policies and regulations, each of which refer to and depend upon one another, make it very unclear which set of provisions govern a particular research protocol. When two understaffed, overworked, and overwhelmed governmental organizations potentially have jurisdiction over a matter, there is a good chance that each will defer to the other. Much research may fall between the cracks with no effective oversight whatever. This latter problem is likely to be a growing issue as federal funding to support research diminishes and private funding from pharmaceutical companies and other sources plays an increasing role in human subject research.¹³²

IV. WHERE DO WE GO FROM HERE?

I offer three recommendations.

1. There needs to be a common set of rules governing human subjects research regardless of the source of funds or the auspices under which research is done. People are at risk not only from federally funded research, but from an increasing volume of research that is privately funded. A recent article in *The New York Times* reported that this research has created a new phenomenon — Commercial Review Boards — that has generated a wave of IRB shopping by researchers.¹³³ The current system of federal regulation which covers federally funded research, and a patchwork quilt of state regulations, leaves many voids and inconsistencies in the rules governing research, which

129. NEW YORK PUB. HEALTH LAW, § 2445 (McKinney 1997).

130. See 45 C.F.R. § 46.116(e) ("The informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective.").

131. See NEW YORK PUB. HEALTH LAW, § 2444(2).

132. See Stolberg, *supra* note 120, at A1, A16.

133. See *id.* at A16; see also Stecklow & Johannes, *supra* note 20 (describing 44 trials in which researchers sought approvals from outside IRBs, including one 2500 miles away, rather than going through the on-campus IRB of the Medical College of Georgia).

themselves foster confusion in a highly complex arena.¹³⁴ A common set of rules could be achieved either by enactment of comprehensive federal legislation or through an approach similar to the adoption of uniform state laws as are currently in place in many other subject areas such as commercial codes.

Any set of rules, however, will be subject to interpretation and application. At present, IRBs have great discretion in their definition and application of the terminology of regulations. Given the mind-set of IRBs and researchers as described earlier, with a bias in favor of research, and an impatience with bureaucratic procedures that impede or delay research efforts, it is not unreasonable to be concerned that this discretion will be exercised to classify terms in a manner that assures the smoothest approvals and a minimum of avoidable disclosure.¹³⁵ But even the most conscientious of researchers and IRBs, working in good faith, would find it difficult to wade through a legal minefield of ambiguity inherent in the current laws and regulations. It is important that a common set of rules be accompanied by practice commentaries that provide more concrete guidance in the application of the rules. Over time, the publication and continued updating of such commentaries, based on actual experiences of IRBs could promote a common understanding of and practical guidelines for dealing with issues such as the following:

- What is an "experiment?" Is the unlabeled or unconventional use of a medication that has been approved by the FDA for another purpose an experiment requiring compliance with a research protocol?
- What is "therapeutic" research? Is it sufficient to classify a research protocol as "therapeutic" if the participants in that research derive incidental benefits such as full medical workups that are unrelated to their condition but necessary for the research itself, although the goal of the research is unrelated to a direct benefit to the individual?
- What is a "benefit" of research that must be balanced against the risks entailed? Is it sufficient to argue, as the researchers in the Tuskegee syphilis study did, that the benefits included free aspirin, "spring tonics," a \$50 burial payment, and the psychological reassurance of having people come all the way from Washington to examine

134. See DeRenzo, *supra* note 66, at 543.

135. See Williams, *supra* note 70.

them periodically,¹³⁶ or to argue, as did the research team at Willowbrook, that the benefits offsetting the deliberate infection of residents with live hepatitis virus included being placed on wards which were cleaner, better supervised and had a much higher nurse to resident ratio than the general wards?¹³⁷

- What is a "risk?" Does this include only the immediate and specific harm that could directly result from the experimental procedure, or does it also include ancillary risks and harm to the subject and his long-term welfare, including relationships with family members and others.¹³⁸
- What is "an adverse consequence" which requires reporting to the OPRR?¹³⁹ For example, is it appropriate not to report the death of a patient known to be at high cardiac risk who was placed in a study on the effect of deprenyl without a screening electrocardiogram, and died from what the medical examiner's report characterized as a sudden cardiac event? In one reported incident, the patient was taking other medications in addition to the deprenyl in the experiment and had chronic blood pressure changes.¹⁴⁰ However, the researchers concluded that it was highly unlikely that his death was related to the research, and no report was filed with the FDA despite a recommendation to do so from the incident review committee.¹⁴¹
- What is a "minimal risk?"¹⁴² The effect of characterizing an experiment as presenting minimal risks is that the IRB may approve a consent procedure that alters some or all of the informed consent elements listed in the federal regulations, or the IRB may waive the requirements entirely.¹⁴³ The IRB controls the process of both analyzing

136. David J. Rothman, *Were Tuskegee and Willowbrook "Studies in Nature?"*, 1982 HASTINGS CENTER REP. 5, 6 (Apr. 1982).

137. *See id.*

138. *See Meslin, supra* note 70, at 8.

139. Protection of Human Subjects, 45 C.F.R. § 46.103(4), (5) (1997).

140. *See* Brief of Plaintiffs-Appellants to New York State Court of Appeals at 20-21, *T.D. v. New York State Office of Mental Health*, 650 N.Y.S.2d 173 (1996) (No. 5136/91).

141. *See id.* at 20-21.

142. 45 C.F.R. § 46.102(g); *see also* Jessica Berg, *Legal and Ethical Complexities of Consent with Cognitively Impaired Research Subjects: Proposed Guidelines*, 24 J.L. MED. & ETHICS 18, 24 (1996).

143. *See* 45 C.F.R. § 46.116; *see also* Delgado & Leskovac, *supra* note 21, at 125; Williams, *supra* note 70.

the risks and characterizing them.¹⁴⁴ How do researchers and IRBs characterize research protocols involving drug washout periods or double blind randomized trials with placebos? Do lumbar punctures and PET scans fall in the category of "minimal risk," "a minor increase over minimal risk," or "more than minimal risk?"

2. The IRB process and its decisions must be made more visible and accountable to more than just the research community. A massive federal oversight presence in human subject research is neither possible nor desirable. However there are alternatives that could accomplish the goal of accountability. Among these alternatives are expanding the membership of IRBs to require representation of primary consumers, family members, advocates and ethicists who are independent of the institutions with which the researchers are affiliated. Additionally, the reports of the IRBs should routinely be made available to important stakeholder groups as a means of informing them about the research being undertaken, and the results and adverse consequences of the research. The groups should include consumer and family organizations, advocacy organizations, and relevant state legislative committees overseeing health and mental health services. The dissemination of these reports more broadly would: (a) create an expectation that the reports be more informative than they are at present; and (b) inform constituencies besides the research community of the benefits, risks and adverse consequences of research, and issues such as the classification of research and the interpretation of key terms in research regulations.

3. Finally, there should be a serious reconsideration of whether there is any justification at all for non-therapeutic research which exposes incapable people to significant risks, especially when they have not explicitly authorized a proxy to consent on their behalf to specified types of research. While competent adults are free to make martyrs of themselves in the cause of science, they do not have the license to make martyrs of other people by volunteering them for experiments that expose them to significant risks, especially when those experiments cannot do them any good. The authorization for such research must reliably and authentically find its source in the exercise of free will by the subject when competent. Henry Beecher, who wrote a pioneering work on abuses in research, noted:

Ordinary patients will not risk their health or their life for the sake of "science." Every experienced clinician knows this.

144. See Delgado & Leskovac, *supra* note 21, at 125.

When such risks are taken and a considerable number are involved, it may be assumed that informed consent has not been obtained in all cases. . . . I have worked on the ward of a large hospital for 35 years, [and] I know perfectly well that ward patients will not . . . volunteer for any such use of themselves for experimental purposes when the hazard may be permanent injury or death.¹⁴⁵

Why is it that some countries like Great Britain and states such as California, Massachusetts, Illinois, Connecticut and many others¹⁴⁶ can ban such research entirely? What price do they pay for these decisions? What is the force of the evidence of need for non-therapeutic research upon incapable human subjects, especially when there are examples of such protocols later being used solely with capable subjects?¹⁴⁷

In this regard, the recent report of the Advisory Committee on Human Radiation Experiments is instructive:

The Advisory Committee reserved its harshest criticism for those cases in which physicians used patients without their consent as subjects in research from which the patients could not possibly benefit medically The heart of the Hippocratic ethic is the physician's commitment to putting the interests of the patient first. Subjecting one's patient to experimentation that offers no prospect of direct benefit to the patient without his or her consent is a direct repudiation of this commitment. . . . Because risks to subjects cannot be offset by the possibility that they might benefit medically, nontherapeutic research that puts subjects at significant risk is rarely justifiable. Participation in such research is always a burden and never a benefit to the individual subject, making questions of justice straightforward as well.¹⁴⁸

By permitting surrogate consent for non-therapeutic research on incapable subjects who have not previously selected and empowered the surrogate while competent, we are once again placing mentally ill persons in a class by themselves — the only people who now appear to have a *duty* of beneficence that no other citizen has — and a duty

145. Letter from Henry K. Beecher to Joseph Sadusk, June 7, 1965, *quoted in* ROTHMAN, *supra* note 27, at 75.

146. See Bein, *supra* note 27, at 741-42; see also Brief for Proposed Amicus Curiae The Bazelon Center for Mental Health Law et al., at 35-37, T.D. v. N.Y. State Office of Mental Health, 650 N.Y.S.2d 173 (N.Y. App. Div. 1996) (No. 5136/91).

147. See *supra*, note 80 and accompanying text.

148. ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS, *supra* note 29, at 406, 408.

exercised by someone else not of their choosing. In non-therapeutic research, the primary benefit to the subject is altruism. But if the subject is not competent and is unknowing about what is being done, and has never expressed this desire, what is the benefit?¹⁴⁹ The courts which have been confronted with the question of the legality of this practice have been strong in their repudiation of it.¹⁵⁰

In a related vein we also need to make a serious effort at the national level to define types of research that simply should not be done regardless of who is willing to consent, i.e., experiments that should not be done not only because the subject lacks the ability to consent, but because there is something fundamentally wrong with the experiment itself. We unfortunately have a history replete with examples of experiments done on human beings which are rightly condemned simply for the assault on human dignity that they represent. While it is easy to include the Nazi experiments and the experiments performed by Japanese during the Second World War as examples of such research that should not be done, there obviously has been less consensus that both the Tuskegee Syphilis study and the Willowbrook Hepatitis study might also fit into such a class. In the latter cases, IRBs have not proved an effective safeguard.

A survivor of Mengele's experiments on twins wrote:

If a human being is ever used in the experiments, the scientist must make a moral commitment never to violate a person's human rights and human dignity. . . . [T]he scientists of the world must remember that research is being done for the sake of mankind and not for the sake of science; scien-

149. See Paul Ramsey, *The Patient as Person* 14 (1970).

150. See *T.D. v. New York State Office of Mental Health*, 650 N.Y.S.2d 173 (N.Y. App. Div. 1996), *appeal dismissed* by 680 N.E.2d 617 (N.Y. 1997), *leave to appeal granted* by 684 N.E.2d 281 (N.Y. 1997), and *appeal dismissed* by 1997 WL 785461 (N.Y. Dec. 22, 1997). The court wrote:

We are not dealing here with parental choice among reasonable treatment alternatives, but with a decision to subject the child to non-therapeutic treatments and procedures that may cause harmful permanent or fatal side effects. It follows therefore that a parent or guardian, let alone another adult who may be a member of the child's family, may not consent to have a child submit to painful and/or potentially life threatening research procedures that hold no prospect of benefit for the child and that may have the same result as a denial of necessary medical treatment.

Id. at 192. The appeal in this case to the NY Court of Appeals was dismissed, and this lower court opinion was characterized as an inappropriate advisory opinion that was not necessary to grant the plaintiffs the relief they sought. See *T.D.*, 1997 WL 785461 (N.Y. Dec. 22, 1997).

tists must never detach themselves from the humans that they serve.¹⁵¹

In my view, such categorical limits, difficult as they might be to define and to accept, may be necessary to curb some of the risks to human subjects, and as a supplement to the current process of relying on the notion of informed consent from or on behalf of someone who is incapable of personal consent.

In conclusion, as one who has spent a substantial portion of my adult life working with people with mental disabilities and their families, I know how important a place research holds in offering hope of greater understanding, control, and perhaps a cure for mental disabilities. I share the view that progress has been too slow in coming, and that in funding research, as in many other aspects of public policy, mental disabilities have been a relatively low priority. I share the impatience of families who are desperate for relief from the unimaginable suffering both they and their afflicted relatives endure. But I am also mindful of the cautionary words of Justice Brandeis, "The greatest dangers to liberty lurk in insidious encroachments by men of zeal, well-meaning but without understanding."¹⁵²

151. Eva Mozes-Kor, *The Mengele Twins and Human Experimentation: A Personal Account*, in *THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION* at 2, 53 & 58 (George J. Annas & Michael A. Grodin eds., 1992).

152. *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandeis J., dissenting).