You are a physician in Columbus, Ohio. One of your patients is eligible for a Phase 3 asthma study you are conducting. However, your patient might also be eligible for studies that other doctors in the area are conducting. One or more of these studies might be better than yours for this patient. What are your obligations to the patient? You have no other information to make your decision and no clever way to dodge it.

Results

Chart 1. What are your ethical obligations to your patient?

Of the 264 clinical research professionals that responded to the survey, 93% would talk to the patient about other studies in the area. Thirty-two percent would just inform their patient that they should look into other studies in the area before enrolling in the study. Sixty-one percent would research other studies in the area before talking to the patient. Seven percent would not mention the existence of other studies in the area.
Several respondents commented that the patient has the ultimate responsibility for choosing a study, or no study at all. Too much assistance might infringe on the patient’s autonomy.

Several respondents pointed out that the patient’s welfare must be the top priority (even if it is a hassle for the investigator).

One respondent essentially said that not assisting the patient is a sin of omission, which carries less ethical weight than a sin of commission.

Several respondents questioned the practicality of learning enough about other studies to provide useful advice.

One respondent suggested that, if an investigator learns that his or her study is inferior to another study (e.g., when a patient presents him or her with the consent form from another study) that the investigator should terminate his or her study.

One respondent stated that, “It’s not the investigator’s responsibility to recruit for other studies. As long as your study doesn’t harm the patient, other PIs are responsible for their own studies.”
Sixty-eight percent of respondents would guide their patient through the process of making a decision about participating in any study. Fourteen percent would volunteer information their patient should know. Seventy-nine percent would talk about all studies in the area, while only 21% percent would talk only about their study.
Chart 3. If the person were not your patient, what would your ethical obligations be?

Eighty-one percent of respondents believe they would have the same obligations as above, even if the person were not their patient. Nineteen percent believe they would have fewer obligations, and 2% (!) believe they would have more obligations.

One respondent pointed out that the physician/patient relationship carries with it special obligations.

Chart 4. If you were not a physician or other medical professional, what would your ethical obligations be?

Respondents were fairly evenly split on this question. Thirty-five percent of respondents believe that, if they were not a physician or medical professional, they would have the same obligations as above. Thirty percent believe they would have fewer obligations, and 24% believe they would have more obligations.

Two respondents pointed out that non-physicians might not be qualified to advise patients on other studies.

It is unclear why a person who is not a medical professional would have more obligations than a medical professional.

Discussion

According to U.S. regulations (45 CFR 46 and (21 CFR 50.25(a)(4)), informed consent must include the following basic element:
A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject

This broad statement is taken directly from the Belmont Report. Although the statement does not specifically mention clinical studies, it seems clear that clinical studies can constitute alternative procedures or courses of treatment that might be advantageous to the subject. However, the appropriateness of any procedure or treatment is a question that the patient must decide with advice from his or physician and/or through the informed consent process.

The informed consent process requires, first, that the person obtaining consent be informed himself or herself and, second, that the patient be informed. Clinicaltrials.gov and other online study databases provide limited information about studies. However, that information can be opaque to people without medical training and, without the protocol (or even the consent form), even medical professional can provide only very limited advice about a study.

Ninety-three percent of respondents stated that they would, at least, mention that other studies exist in the area. Sixty-eight percent would offer to guide the patient through the process of choosing a clinical study (or clinical care), which does not require detailed knowledge of all the protocols.

A 2017 revision to the Common Rule states:

For each clinical trial conducted or supported by a Federal department or agency, one IRB-approved informed consent form used to enroll subjects must be posted by the awardee or the Federal department or agency component conducting the trial on a publicly available Federal website that will be established as a repository for such informed consent forms. (45 CFR 46.116(h)(1))

If these consent forms are posting in a timely manner, it will be much easier for investigators to research competing studies. However, even with access to consent forms or protocols (which take time to digest) and given that most physician/investigators have plenty to do without researching all the competing studies that might be worthwhile for their patients, a reasonable approach would be for the investigators in a community to make a one-page summary of each of their studies available to appropriate medical professionals in their community. This approach would likely help with patient recruiting for studies of merit. If a patient obtains a consent form for a particular study, he or she can then share it with his or her physician, who can then review it and ask the investigator specific follow-up questions. This approach begs the question: How do the physicians and investigators in a community ensure that they only conduct studies that present a valid option to at least some patients?

The Hippocratic Oath requires physicians to do no harm to their patients. This requirement appears to prohibit a physician from conducting a study that, in his or her professional opinion, is inferior to clinical practice or to other studies reasonably available to his or her patients. While only physicians take the Hippocratic Oath, it is hard to think of a reason why every clinical research professional should not be held to this same ethical standard (which is not really that high), to the extent they are able to comply — the regulations governing clinical research do not set forth different ethical standards for different occupations.

While equipoise for the intended subject population is required for IRB approval, it is just a minimal requirement. There is no requirement that a specific physician must agree with the IRB’s conclusion for a specific patient. Also, even though two competing studies are both in equipoise, a physician is likely to conclude that one is superior to the other for a specific patient.
This leaves the investigator with three options:

- Obtain adequate information about competing studies in advance.
- Review information about other studies that the investigator happens to see, e.g., from a patient considering a study.
- Adopt a policy of willful ignorance.

The first approach appears to be the most ethical but also the least practical. The second approach appears to be half-hearted, at best. The third approach appears to be the least ethical and, for what it’s worth, is no defense in the U.S. legal system.

It behooves the clinical research enterprise to support high ethical standards with the first approach. However, given the heavy load that clinical research already puts on investigators, we need to minimize the additional load and fairly compensate investigators for any additional work.

**Next Month’s Question**

You are the director of human research protection at a community hospital. You have one IRB with seven members. Six of the members are physicians with staff privileges at your hospital. The seventh member, a representative from the community, just resigned from the IRB. Six qualified people have applied to fill the empty seat: a bioethicist, a minister, a former study participant, a community leader, a sociologist, and a member of a disadvantaged group served by the hospital. Because of a hospital policy that is set in stone, you can accept only one new IRB member. Which one do you choose?

Read the full question and give us your answer at:
https://www.surveymonkey.com/r/7BR6MPJ

*Please send your ethical conundrums to ngoldfarb@firstclinical.com.*

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