ETHICAL AND LEGAL ISSUES IN HEALTHCARE

Research ethics and the ethics of research

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A 'long-standing' patient asks for your advice. She is a capable, middle-aged lady and a respected professional in the local community. Her regular three-item prescription successfully manages her previously high blood pressure. She tells you that her GP has asked her to join a group of patients taking a new medicine recently released for the control of blood pressure. It will involve replacing one of her existing medicines with this new one. He has given her explanatory paperwork and asked her to sign a consent form agreeing to be included in a 'double-blind, placebo-controlled trial'. She comments that her blood pressure is well controlled and doesn't think that she should risk being given a placebo in place of her 'proven' medicine. She asks you to advise her as to what would be in her best interests…

"Medical research involving human subjects differs substantially from medical treatment". (Kuhse and Singer). While medical treatment focuses on the healthcare needs of individual, identifiable patients, research generally seeks to improve the health and well-being of current or future *groups* of patients, or of society as a whole. The use of placebos in trials is considered to increase the reliability of such studies. Hence a patient's involvement in research does not necessarily focus on his or her individual 'best interests'. Indeed, the nature of such clinical research being to establish the safety profile of new medicines, there will inevitably be some risk of increased adverse reactions during a trial period. Protection of subjects enlisted in trials is therefore the priority.

In Ireland, The European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004 govern most of the regulation of clinical trials. They define clinical trials as investigations on human subjects, other than non-interventional trials, intended to ascertain the safety or efficacy of medicinal products. Elements included in the regulations are ethics committees, the clinical trials authorisation process, good practice in clinical trials, pharmacovigilance and the manufacture, importation and labelling of investigational medicinal products. The Irish Medicines Board (IMB) is designated the competent authority for granting permission to run clinical trials. The process proposed must be deemed to meet the standards of good clinical practice as specified in the regulations and approval of a study design by an ethics committee is required prior to application to the IMB.

The operation of ethics committees in Ireland, regularly referred to in the literature as Research Ethics Boards (REBs), "are under the supervision of the Minister for Health, who may either recognise committees appointed by institutions or appoint her own committees with either national responsibility or responsibility for particular classes of clinical trials. Where the Minister recognises an ethics committee, she must indicate to them their terms of reference". (Mills). Research ethics boards may therefore be variable in their 'modus operandi'. However, they generally operate under the basic premise that if consent can be feasibly obtained it should be sought. This requirement does raise the concern that opportunities to access existing data in healthcare records are being further restricted and this matter is currently under much debate in the literature (Willison et al). While the specific mandate of ethics committees in non-interventional trials is not always clear, regulation does refer to how consent should be obtained from participants, and to the safeguarding of the rights of each subject to privacy and the protection of data concerning him or her in accordance with the Data Protection Act 1998 and 2003.

The desire to have societal control of the operation of clinical trials evolves largely from the 'Nuremberg' reaction to the atrocities carried out both in German concentration camps and in Japan during World War II. Prisoners were subjected to horrific 'interventions', ostensibly in the name of medical research. The dilemma for humanity was that, given the manner in which this scientifically valuable medical information was amassed, whether it could ever be morally justifiable to use that information for the betterment of human kind. Such justification was deemed to be dependent on an assurance that such atrocities could never recur. The 10-point Nuremberg code, and the subsequent declaration of Helsinki (World Medical Association, 1964), were determined attempts to prevent a re-occurrence by ensuring that the right of an individual to consent to or refuse a healthcare intervention was enshrined in law and, most specifically, in all aspects of medical research.

Despite the outcome of the Nuremberg trials, research ethics continue to have a chequered history; the most notable violation being the Tuskegee Syphilis Study USA (1932–1971). The objective in Tuskegee was to study the nature and course of syphilis on an island community by leaving the people untreated, even though they received free medical examinations on a regular basis. They were told they had 'bad blood', were intentionally not 'drafted' for the war and denied access to penicillin even after it became freely available in 1940. The Tuskegee report (1973) determined that "society can no longer afford to leave the balancing of individual rights against scientific progress to the scientific community". The subsequent Belmont report (1979) reaffirmed the requirement for consent, and added specific additional ethical principles which focussed on assurances that benefits and harm are balanced and that there is an equitable distribution between the burdens and benefits of research. Given the treatment of the residents of Tuskegee (amongst others), there is nothing I would think or write that would be intended to diminish attention to such injustice, or the desire to prevent a re-occurrence of same.

Notwithstanding the above, I do think that new approaches to practice-based research may be required. 'Much health research is heavily dependent on access to information from medical records' (Willison et al 2008). As privacy law and the protection of personal data have become more heavily regulated, access to medical records for research purposes has also become more tightly controlled. The debate has become somewhat focussed on whether there is a risk that even anonymised data might be potentially identifiable. Debate suggests that the use of outside researchers or research assistants to gather data, rather than engaging the primary healthcare professional themselves, increases the likelihood of such breach of privacy. Removal of unnecessarily specific identifiers such as date of birth, when 'year of birth' may be perfectly adequate and/or the utilisation of dispensing software to encode identifiers in such a manner that only the practitioner caring for the patient could subsequently re-identify the patient, are further approaches that could reduce those risks. Pharmacoeconomics research is currently facilitated by the provision of anonymised data from the PCRS – the weakness in that system being that the database, which excludes non-reimbursed medicines, is incomplete. It would appear that there is an undeveloped role that practitioners could legitimately play in making existing records of dispensing available for research and collation purposes, the skill-set required for which is not unrelated to data review for quality improvements.

There should be no intention of diminishing respect for autonomy, or the rights to privacy or confidentiality, but rather to seek more appropriate means by which to maximise opportunities to promote the 'greater good' while adhering to the core principle of 'do no harm'.

Going back to the patient who asked for advice as to whether I thought her involvement in this double-blind, placebo-controlled trial was in her best interest. I could not pretend that to be the case. I have to accept that encouraging a specific patient to involve herself in a double-blind, placebo-controlled trial is tantamount to telling her that a placebo is an acceptable element in her care. This type of scenario represents the classic conflict between patient-focussed care and a strategic approach to population health – a discussion topic particularly neglected in continuing education/professional development for community pharmacy practice. Notwithstanding the detail of the above scenario, and the presumption that the GP will be satisfied that a particular patient will be unlikely to come to harm by being involved in the trial, the principles of responsibility to 'the greater good' and the use of placebos in healthcare continue to be a source of unease for practitioners.

It seems that the adverse implications of such 'unease' could be ameliorated by exploring ways in which academia and practitioners could effectively collaborate; with practitioners, rather than attempting to become researchers, instead developing an ethically and academically acceptable system for extracting anonymised data from records held on file, and those in research having an opportunity to facilitate practitioners in maximising what contributions they can make to the 'greater good' of healthcare research.

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