

## Assessment of Capacity to Give Consent to Research Participation: State-of-the-Art and Beyond

Evan G. DeRenzo

Robert R. Conley

Raymond Love

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Bioethics and Medical Ethics Commons](#), and the [Health Law Commons](#)

---

### Recommended Citation

Evan G. DeRenzo, Robert R. Conley, & Raymond Love, *Assessment of Capacity to Give Consent to Research Participation: State-of-the-Art and Beyond*, 1 J. Health Care L. & Pol'y 66 (1998).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol1/iss1/5>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact [smccarty@law.umaryland.edu](mailto:smccarty@law.umaryland.edu).

# ASSESSMENT OF CAPACITY TO GIVE CONSENT TO RESEARCH PARTICIPATION: STATE-OF-THE-ART AND BEYOND\*

EVAN G. DERENZO, PH.D.,\*\*  
ROBERT R. CONLEY, M.D.,\*\*\*  
RAYMOND LOVE, PHARM.D.\*\*\*\*

## INTRODUCTION

For well over a year, the Maryland Attorney General's Working Group on Conducting Research on the Cognitively Impaired has been considering the involvement of persons unable to give their own consent to participate in biomedical and behavioral research.<sup>1</sup> The group's goal has been to develop proposed legislation to clarify the ethically and legally acceptable conditions under which such persons may, or may not, be involved in human subjects experimentation.<sup>2</sup> If the legislation proposed by the Working Group is passed, it will establish the state of Maryland, and the thoughtful, open and deliberative process created by the Maryland Attorney General's Office, as a model of how public policy in health care ought to be developed.

The Working Group's starting point is the adult who has become unable to provide his or her own consent for research participation prior to study entry as a result of insufficient decision-making capacity.<sup>3</sup> In this paper the authors use the term decisionally impaired for

---

\* The ideas and opinions expressed in this paper are those of the author's only and do not represent any position or policy of any federal agency, or any other institution or organization to which they are affiliated.

\*\* Senior staff fellow in the Department of Clinical Bioethics at the National Institutes of Health. Her present research interests focus on ethical issues involving cognitively and psychiatrically impaired persons in research, as well as ethical issues in oncology and genetics.

\*\*\* Assistant Professor of Psychiatry, University of Maryland, School of Medicine. Dr. Conley is also the Director of the Treatment Research Program at the Maryland Psychiatric Research Center.

\*\*\*\* Associate Professor and Vice Chair of Pharmacy Practice and Science, University of Maryland, School of Pharmacy.

1. See Jack Schwartz, Office of Md. Att'y Gen., Second Report of the Maryland Attorney General's Working Group (May 1998) (the Second Report is reprinted in the Appendix to this issue of the *Journal of Health Care Law & Policy*) [hereinafter Second Report].

2. See *id.* at 1.

3. See *id.* at 2.

this category of person.<sup>4</sup> Beginning with the decisionally impaired adult is consistent with the majority of philosophic, public policy, and empirical research literature addressing the ethics of involving decisionally impaired persons in biomedical and social science research.<sup>5</sup>

The prospect of finally developing useful, appropriate, and specific protections for medical and social science research involving decisionally impaired persons seems to be a realistic possibility. That is because discussions about the ethics of involving decisionally impaired persons in research have been going on for many years and have become increasingly sophisticated and focused.<sup>6</sup> Now that this

4. For a more complete discussion of why this terminology is used and who is included by this term, see Evan G. DeRenzo, *Decisionally Impaired Persons In Research: Refining the Proposed Refinements*, 25 J. L. MED. & ETHICS 139 (1997).

5. See generally Jessica Wilen Berg, *Legal and Ethical Complexities of Consent with Cognitively Impaired Research Subjects: Proposed Guidelines*, 24 J. L. MED. & ETHICS 18 (1994); Richard J. Bonnie, *Research with Cognitively Impaired Subjects*, 54 ARCH. GEN. PSYCHIATRY 105 (1997); William T. Carpenter et al., *The Rationale and Ethics of Medication-Free Research in Schizophrenia*, 54 ARCH. GEN. PSYCHIATRY 401 (1997); S.J. Delano & J.L. Zucker, *Protecting Mental Health Research Subjects Without Prohibiting Progress*, 45 HOSP. & COMMUNITY PSYCHIATRY 601 (1994); Evan Gaines DeRenzo, *The Ethics of Involving Psychiatrically Impaired Persons in Research*, IRB, Nov.-Dec. 1994, at 7; Evan Gaines DeRenzo, *The Ethics Of Involving Severely Cognitively Impaired Persons in Research: The Continuing Debate*, 3 CAMBRIDGE Q. HEALTHCARE ETHICS 539 (1994); Rebecca Dresser, *Mentally Disabled Research Subjects: The Enduring Policy Issues*, 276 JAMA 67 (1996); Carl Elliot, *Caring About Risks*, 54 ARCH. GEN. PSYCHIATRY 113 (1997); Joseph J. Fins & Franklin G. Miller, *The Call of the Sirens: Navigating the Ethics of Medication-Free Research in Schizophrenia*, 415 ARCH. GEN. PSYCHIATRY 113 (1997); K.W.M. Fulford & K. Howse, *Ethics of Research with Psychiatric Patients: Principles, Problems and the Primary Responsibilities of Researchers*, 19 J. MED. ETHICS 85 (1993); Kathleen Cranley Glass & Marc Speyer-Ofenberg, *Incompetent Persons as Research Subjects and the Ethics of Minimal Risk*, 5 CAMBRIDGE Q. HEALTHCARE ETHICS 362 (1996); Fritz A. Henn, *A European Perspective*, 54 ARCH. GEN. PSYCHIATRY 412 (1997); Dallas M. High et al., *Guidelines for Addressing Ethical and Legal Issues in Alzheimer Disease Research: A Position Paper*, 8 ALZHEIMER'S DISEASE & ASSOCIATED DISORDERS 66 (1994); Edward W. Keyserlingk et al., *Proposed Guidelines for the Participation of Persons with Dementia as Research Subjects*, 38 PERSPECTIVES BIOLOGY & MED. 319 (1995); Greg A. Sachs, *Advance Consent for Dementia Research*, 8 ALZHEIMER'S DISEASE & ASSOCIATED DISORDERS 19 (1994); Greg A. Sachs et al., *Ethical Aspects of Dementia Research: Informed Consent and Proxy Consent*, 42 J. CLINICAL RES. 403 (1994).

6. See generally THE NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, DEP'T OF HEALTH EDUC. AND WELFARE, PUB. NO. (OS) 78-0006, REPORT AND RECOMMENDATIONS: RESEARCH INVOLVING THOSE INSTITUTIONALIZED AS MENTALLY INFIRM (1978); JAY KATZ & ALEXANDER MORGAN CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? (1975); H. Helmchen, *Problems of Informed Consent to Clinical Trials in Psychiatry*, 1 CONTROLLED CLINICAL TRIALS 435 (1981); Ruth Macklin, *Some Problems in Gaining Informed Consent from Psychiatric Patients*, 31 EMORY L. J. 345 (1982); PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH. MAKING HEALTH CARE DECISIONS: VOL. 1: REPORT 168 (U.S. Gov't Printing Office: 1982); Barbara Stanley, *Senile Dementia and Informed Consent*, 1 BEHAV. SCI. & L. 57 (1983); James F. Drane, *The Many Faces of Competency: The Greater the Risk, The Stricter the Standard*, HASTINGS CENTER REPORT, April 1985, at 17; Virginia R. Cassidy & Lorys F. Oddi, *Legal and Ethical Aspects of Informed Consent: A Nursing Research Perspec-*

possibility is coming closer to realization, discussions have begun shifting to the prior issue of assessment of capacity to give research consent.<sup>7</sup>

As attention is directed towards the process of assessing capacity to provide ethically and legally valid consent to research participation, three important facets of this issue emerge. First, appreciation for the primitive nature of our ability to assess decisional capacity is growing.<sup>8</sup> Second, old debates around who ought to be performing, or be involved in, capacity assessment have been revived.<sup>9</sup> Third, the need to develop more refined and standardized assessment tools as adjuncts to clinical judgment has become more pressing.<sup>10</sup>

This paper addresses these three points. More specifically, it will give a selective review of the relevant historical antecedents that have influenced progress to date, discuss the ethical tensions inherent in considerations of assessment of capacity to give research consent, present the on-going work of our group in this area and the related work of others, and set a path for future research and debate that is necessary to advance the ethical standards of the conduct of biomedical and behavioral research with decisionally impaired persons.

### *How We Have Come to Where We Are Today: Convergence of Historical Factors*

A patient or subject's capacity to make decisions has been an important consideration from the earliest discussions of the doctrine of

---

*tive*, J. PROF. NURSING, Nov.-Dec. 1986 at 343; Vijaya L. Melnick et al., *Clinical Research in Senile Dementia of the Alzheimer's Type. Suggested Guidelines Addressing the Ethical and Legal Issues*, in ALZHEIMER'S DEMENTIA: DILEMMAS IN CLINICAL RESEARCH 295 (Vijaya L. Melnick & Nancy Dubler eds., 1985); ALLEN E. BUCHANAN & DAN W. BROCK, DECIDING FOR OTHERS: THE ETHICS OF SURROGATE DECISION MAKING (1989); American College of Physicians, *Cognitively Impaired Subjects: Position Paper*, 111 ANN. INTERN. MED. 843 (1989); Greg A. Sachs & Christine K. Cassel, *Biomedical Research Involving Older Human Subjects*, 8 LAW, MEDICINE & HEALTH CARE 234 (1990); D. Becker, *Informed Consent in Demented Patients: A Question of Hours*, 12 LAW & MED. 271 (1993); Ruth Macklin, *Philosophical Conceptions of Rationality and Psychiatric Notions of Competency*, 57 SYNTHESIS 205 (1983); A. Donald Milliken, *The Need for Research and Ethical Safeguards in Special Populations*, 38 CANADIAN J. PSYCHIATRY 681 (1993).

7. See *infra* notes 8-10 and accompanying text.

8. See generally BECKY COX WHITE, COMPETENCE TO CONSENT (1994); Paul S. Appelbaum, *Rethinking the Conduct of Psychiatric Research*, 54 ARCH. GEN. PSYCHIATRY 117 (1997); Testimony of Paul S. Appelbaum before the National Bioethics Advisory Commission (NBAC) Transcripts 2/2 at 2-7 (July 15, 1997) (transcripts on file with Evan DeRenzo) [Hereinafter NBAC testimony of Paul S. Appelbaum].

9. See NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 6, at 13; DeRenzo, *supra* note 4, at 19-20; Bonnie, *supra* note 5, at 107-109.

10. See generally NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 6.

informed consent.<sup>11</sup> Interestingly, as important as capacity is, its assessment has not been a focus of much empirical attention. Rather, the literature, particularly the early literature on empirical studies of informed consent, clusters around studies looking at information exchange and understanding of information disclosed.<sup>12</sup> Many of these studies are poorly designed resulting in equivocal findings.

As the data have evolved, however, the majority of studies conclude that seriously ill research subjects have difficulties in many facets of providing ethically valid consent.<sup>13</sup> This has also been the finding in a majority of the few studies specifically investigating capacity to provide consent.<sup>14</sup> Only one well-designed series of studies has concluded that seriously ill subjects are able to give ethically valid informed consent to research.<sup>15</sup>

The Stanley et al. studies compared psychiatrically and somatically ill subjects in a setting where they were asked to consider consenting to hypothetical research projects.<sup>16</sup> As the psychiatric subjects' consent behavior was not statistically different from that of the somatic subjects, and because their patterns of consent and refusal were comparable to those of the somatically ill subjects, the investigators concluded that the psychiatrically ill subjects were providing valid informed consent.<sup>17</sup>

---

11. See generally JAY KATZ, *EXPERIMENTATION WITH HUMAN BEINGS* (1972); KATZ & CAPRON, *supra* note 6; A. Meisel et al., *Toward a Model of the Legal Doctrine of Informed Consent*, 134 AM. J. PSYCHIATRY 285 (1977); Thomas S. Szasz & Marc H. Hollender, *The Basic Models of the Doctor-Patient Relationship*, 97 ARCHIVES INTERNAL MED. 585 (1956).

12. See generally CHARLES W. LIDZ ET AL., *INFORMED CONSENT: A STUDY OF DECISIONMAKING IN PSYCHIATRY*, CHAPTER 3 (1984); Alan Meisel & Loren H. Roth, *Toward An Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265 (1983); Alan Meisel & Loren H. Roth, *What We Do and Do Not Know About Informed Consent*, 246 JAMA 2473 (1981); Laurence Tancredi, *Competency for Informed Consent: Conceptual Limits of Empirical Data*, 5 INT'L J.L. & PSYCHIATRY 51 (1982).

13. See, e.g., LIDZ ET AL., *supra* note 12; ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS: FINAL REPORT (1995); Monica H. Schaeffer et al., *The Impact of Disease Severity on the Informed Consent Process in Clinical Research*, 100 AM. J. MED. 261 (1996).

14. See, e.g., Paul S. Appelbaum et al., *Empirical Assessment of Competency to Consent to Psychiatric Hospitalization*, 138 AM. J. PSYCHIATRY 1170 (1981); Caroline L. Kaufman & Loren H. Roth, *Psychiatric Evaluation of Patient Decision-Making: Informed Consent to ECT*, 16 SOC. PSYCHIATRY 11 (1981); Debbie Schachter et al., *The Effect of Psychopathology on the Ability of Schizophrenic Patients to Give Informed Consent*, 182 J. MENT. DIS. 360 (1994); Barbara Stanley et al., *The Functional Competency of Elderly at Risk*, 28 GERONTOLOGIST 53 (1988).

15. See generally Barbara Stanley et al., *Informed Consent and Competency in Psychiatric Research*, 138 AM. J. PSYCHIATRY 669 (1981); Barbara Stanley & Michael Stanley, *Psychiatric Patients' Comprehension of Consent Information*, 23 PSYCHOPHARMACOLOGY BULL. 375 (1987).

16. See generally *id.*

17. See Stanley et al., *supra* note 15, at 671; see also Stanley & Stanley, *supra* note 15, at 377.

The foundational assumption was that somatically ill persons provide ethically and legally valid consent.<sup>18</sup> Other work questions this assumption.<sup>19</sup> The counter interpretation is that many research subjects have impaired decisional capacity, whether somatically or psychiatrically ill.<sup>20</sup> This interpretation has been well supported. In an influential and often cited study of fifty-two female subjects involved in a labor-induction study, twenty (39%) were found to be unaware that they were research subjects, although all had signed consent documents.<sup>21</sup> Further, of those who knew they were part of a study, there were frequent misunderstandings of essential aspects of study participation.<sup>22</sup>

These findings have been supported by more recent investigations. In a study of cardiac and cancer research subjects undertaken by the President's Advisory Committee on Human Radiation Experiments, confusion about study participation was widespread.<sup>23</sup> Some study subjects did not know they were in research although they had signed consent documents.<sup>24</sup> Others, who were not part of a research protocol, thought they were.<sup>25</sup>

In another investigation, which was designed to assess the efficacy of the informed consent process in subjects with a range of disease severity,<sup>26</sup> the study showed that as disease severity increases the ability of subjects to retain information from the consent process decreases.<sup>27</sup> In short, the sicker the patient-subject, the less able the individual was to remember essential information central to his or her research participation.

---

18. See Stanley et al., *supra* note 15, at 669; see also Stanley & Stanley, *supra* note 15, at 375.

19. See Stanley et al., *supra* note 15, at 670-71 (Results indicated that the level of psychopathology may not be a good index of patient's ability to consent to participation, these results contradict frequent assumptions that the more severely disturbed the patient is, the less able he or she is to evaluate research risks.); see also Stanley & Stanley, *supra* note 15, at 375. In a study that examined psychiatric and medical patients' willingness to participate in a series of hypothetical studies, no differences were found between the two patient groups. See *id.* at 375-76. Both psychiatric and medical patients agreed to participate in the studies in a manner which was consistent with the level of risk attendant to the study protocol. See *id.* at 376.

20. See *id.*

21. See BRADFORD H. GRAY, HUMAN SUBJECTS IN MEDICAL EXPERIMENTATION 96 (1975); Bradford H. Gray, *Complexities of Informed Consent*, 437 ANNALS AM. ACAD. POL. & SOC. SCI. 37, 43 (1978).

22. See Gray, *supra* note 21, at 103.

23. ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, *supra* note 13, at 737.

24. See *id.* at 736-37.

25. See *id.*

26. See Schaeffer, *supra* note 13, at 261.

27. See *id.* at 264.

The largest and most important body of empirical studies of informed consent to research has produced replicable data demonstrating serious impairments on the part of subjects to provide ethically and legally valid consent.<sup>28</sup> Because this corpus has been produced by psychiatric researchers, it has concentrated on decisional capacity in psychiatric research subjects. In a landmark investigation, Lidz et al. demonstrated systematic and pervasive confusions on the part of subjects and investigators about the differences between research and clinical care.<sup>29</sup> Subjects confused research goals with an intent to be treated.<sup>30</sup> Moreover, investigators confused these distinctions, as well.<sup>31</sup>

In laying the groundwork for this seminal study,<sup>32</sup> the investigators shaped the five requirements of the doctrine of informed consent (information, understanding, competency, voluntariness and the decision, itself) into the following questions:

1. Information: What was disclosed, how, when, and by whom?<sup>33</sup>
2. Understanding: What did the patient understand about the treatment?<sup>34</sup>
3. Competency: If the patient did not understand, did he or she have the cognitive capacity to do so?<sup>35</sup>
4. Voluntariness: Was the patient free to choose? Was he or she subject to coercion or undue influence?<sup>36</sup>
5. Decision: What was the overall structure of the way in which decisions about treatment were made? What role did the formal disclosure play?<sup>37</sup>

None of these questions have yet been fully answered. They have, however, garnered increasing attention, including question two and its derivatives, such as: If the subject signed a consent form, was the person sufficiently capacitated to do so? and How do we assess capacity to give initial and on-going consent to research participation in a questionably capacitated individual?<sup>38</sup> Although there is much re-

28. See *supra* note 14.

29. See LIDZ ET AL., *supra* note 12, at 28.

30. See *id.*

31. See *id.* at 26.

32. See generally *id.*

33. See *id.* at 24-25.

34. See *id.* at 25-28.

35. See *id.*

36. See *id.* at 28-30.

37. See *id.* at 28.

38. See generally Applebaum et al., *supra* note 14; Kaufman & Roth, *supra* note 14; Schachter et al., *supra* note 14; Stanley et al., *supra* note 14.

search and ethical analysis yet to be done, the ground breaking work begun in this study and continued by this group have been invaluable to advancing knowledge and discussion of these complex research and research ethics issues.

One contribution stands out among the many. That is, this group has consistently found a specific kind of confusion on the part of patients about the purpose of their research participation.<sup>39</sup> This phenomenon has been consistently replicated and is now widely acknowledged.<sup>40</sup> Since publication of their earliest studies, Lidz et al. have reproduced this finding with such consistency that they have given this confusion the name "therapeutic misconception."<sup>41</sup> The therapeutic misconception is the notion that research subjects view their study participation as really being for their clinical benefit.<sup>42</sup> This notion is now generally accepted and is part of the common vocabulary of scientists and ethicists involved in this research domain.<sup>43</sup>

The notion of the therapeutic misconception is now being taken seriously in large part because the work of this psychiatric research group has reached a critical mass, sufficient to cause a shift in beliefs and scientific notions.<sup>44</sup> In fact, it is not an overstatement to suggest that the respect engendered by this group's work and its sheer volume, coupled with a grudging acceptance of the veracity of their notion of the "therapeutic misconception," have brought us to a point at which serious clinical, empirical, and public policy attention is now being paid to assessment of capacity to consent to medical treatment

---

39. See generally *id.*

40. See generally Michael Bamberg & Nancy Budwig, *Therapeutic Misconceptions: When the Voices of Caring and Research Are Misconstrued as the Voice of Curing*, 2 ETHICS & BEHAV. 165 (1992); NBAC testimony of Paul S. Appelbaum, *supra* note 8.

41. Paul S. Appelbaum et al., *False Hope and Best Data: Consent to Research and the Therapeutic Misconception*, HASTINGS CENTER REPORT, April 1987, at 20; see generally Paul S. Appelbaum et al., *The Therapeutic Misconception: Informed Consent in Psychiatric Research*, 5 INT'L J.L. & PSYCHIATRY 319 (1982); Loren H. Roth et al., *Informed Consent in Psychiatric Research*, 39 RUTGERS L. REV. 425, 436 (1987); Loren H. Roth & Paul S. Appelbaum, *Obtaining Informed Consent for Research with Psychiatric Patients: The Controversy Continues*, 6 PSYCHIATRIC CLINICS N. AM. 551 (1983).

42. Paul S. Appelbaum et al., *The Therapeutic Misconception: Informed Consent in Psychiatric Research*, *supra* note 41, at 320.

43. See generally *supra* note 41; Paul R. Benson et al., *Information Disclosure, Subject Understanding, and Informed Consent in Psychiatric Research*, 12 LAW & HUM. BEHAV. 455 (1988); Paul R. Benson et al., *Informed Consent in Psychiatric Research: Preliminary Findings From an Ongoing Investigation*, 20 SOC. SCI. & MED. 1331 (1985); Thomas Grisso & Paul S. Appelbaum, *Mentally Ill and Non-Mentally-Ill Patients' Abilities to Understand Informed Consent Disclosures for Medication: Preliminary Data*, 15 LAW & HUM. BEHAV. 377 (1991).

44. See generally THOMAS S. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* (1970).



and research.<sup>45</sup> But an accumulation of sound data seems not to be the only reason there is a growing urgency to attention of the ethics and study of assessment of capacity to provide research consent.

In addition to the evolution of scholarly attention to consent issues in research involving decisionally impaired persons, historically relevant socio-political influences have contributed importantly to bringing us to where we are today. These include a general shift away from acceptance of authority to a cultural norm of skepticism. The counter-culture movement of the 1960's that sprung up in opposition to the Vietnam War ushered in an era of heightened questioning and doubt. Contemporaneous to this rise in generalized skepticism were revelations of abuse in medical research by American physician-investigators outside<sup>46</sup> and inside<sup>47</sup> the Federal government, increasing mistrust of authority, in general, and the medical profession and medical research community more specifically.<sup>48</sup>

Part and parcel of this change in cultural levels of trust and respect for authority have been the increased appreciation for cultural diversity.<sup>49</sup> With an acceptance of diversity has come increased political and consumer power of various subpopulations in the culture, such as the Black Power and Women's movements.<sup>50</sup> Acceptance of multiculturalism has led to an awareness that the existing medical power structure does not necessarily represent the multicultural nature of the nation's population.<sup>51</sup> Therefore, it is now readily acknowledged that there often are value differences between doctor and patient that may influence medical decision-making.<sup>52</sup>

With an appreciation for the divergence of values between doctor and patient, and general deconstruction of old notions of objectivity

---

45. WHITE, *supra* note 8, at xi - xiv; *see also, e.g.*, Paul S. Appelbaum & Thomas Grisso, *The MacArthur Treatment Competence Study. I*, 19 LAW & HUM. BEHAV. 105 (1995); Thomas Grisso et al., *The MacArthur Treatment Competence Study. II*, 19 LAW & HUM. BEHAV. 127 (1995); Thomas Grisso & Paul S. Appelbaum, *The MacArthur Treatment Competence Study. III*, 19 LAW & HUM. BEHAV. 149 (1995); *see also* NBAC testimony of Paul S. Appelbaum, *supra* note 8.

46. *See generally* Henry K. Beecher, *Ethics and Clinical Research*, 274 NEW ENG. J. MED. 1354 (1966) (giving examples of questionably ethical practices in medical schools and university hospitals).

47. *See generally* JAMES H. JONES, *BAD BLOOD: THE TUSKEGEE SYPHILIS EXPERIMENT* (1993).

48. *See generally* DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* (1991).

49. *See e.g.*, HARLEY E. FLACK & EDMUND D. PELLEGRINO, *AFRICAN-AMERICAN PERSPECTIVES ON BIOMEDICAL ETHICS* at v (1992).

50. *See id.*

51. *See id.* at vii.

52. *See id.* at ix.

in science, a sea change in locus of control of medical decision-making has taken place. Much that was previously understood to be based on objective scientific fact is now recognized as subjectively determined or influenced.<sup>53</sup> That is, today there is a growing recognition that physician recommendations are not simply grounded in medical fact, but filtered through the physician's subjective interpretation of medical, as well as psycho-social data.<sup>54</sup> Relatedly, recognition of this subjectivity has illuminated unacceptable power differentials in the doctor-patient relationship resulting in further change in traditional models of doctor-patient interaction.<sup>55</sup>

Finally, the specter of abuse of vulnerable subjects has resurfaced glaringly over the last several years. Charges of abuse resulting from problems in schizophrenia research,<sup>56</sup> and revelations about radiation experiments conducted by the United States government<sup>57</sup> have rekindled memories of local<sup>58</sup> and foreign<sup>59</sup> atrocities committed on vulnerable research subjects, many of whom were mentally retarded, psychiatrically ill and/or minors.<sup>60</sup> Rapid advances in genetics have also triggered horrible memories. These remembered images produce revulsion in the public, further eroding trust and respect for the research community.<sup>61</sup>

In summary, there is renewed attention to incidences of abuse of decisionally-impaired research subjects; there has been a change from assuming objectivity to assuming subjectivity in medical decision-making; there is a growing body of literature that demonstrates poor quality of understanding and retention by research subjects of the

---

53. See Mark R. Tonelli, *Substituted Judgment in Medical Practice: Evidentiary Standards on a Sliding Scale*, 25 J. L. MED. & ETHICS 22, 23 (1997). But see Joshua S. Golden & George D. Johnston, *Problems of Distortion in Doctor-Patient Communications*, 1 PSYCHIATRY MED. 127, 129-31 (1970) (analyzing the results of a study investigating patients' understanding of what physicians tell them).

54. See generally JOSHUA S. GOLDEN & GEORGE D. JOHNSTON, *Problems of Distortion in Doctor-Patient Communications in PSYCHIATRY IN MEDICINE*, 127-49 (1970).

55. See generally HOWARD BRODY, *THE HEALER'S POWER* (1992); JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984); ROTHMAN, *supra* note 48; David Mintz, *What's in a Word: The Distancing Function of Language in Medicine*, 13 J. MED. HUMAN. 223 (1992).

56. See OFFICE FOR PROTECTION FROM RESEARCH RISKS DIVISION OF HUMAN SUBJECT PROTECTIONS, *EVALUATION OF HUMAN SUBJECT PROTECTIONS IN SCHIZOPHRENIA RESEARCH CONDUCTED BY THE UNIVERSITY OF CALIFORNIA LOS ANGELES* (1994).

57. See generally ADVISORY COMM. ON HUMAN RADIATION EXPERIMENTS, *supra* note 13.

58. See generally JONES, *supra* note 47.

59. See generally GEORGE J. ANNAS & MICHAEL A. GRODIN, *THE NAZI DOCTORS AND THE NUREMBERG CODE: HUMAN RIGHTS IN HUMAN EXPERIMENTATION* (1992).

60. See generally *id.*

61. See, e.g., EDWIN R. DUBOSE, *THE ILLUSION OF TRUST: TOWARD A MEDICAL THEOLOGICAL ETHICS IN THE POSTMODERN AGE* 1-3 (1995).

informed consent process; and there is consistent evidence of confusion on the part of researchers and subjects about distinctions between research and clinical care. Given that these factors exist in a broad social context of increasing diversity and consumer power, it is little wonder that the forces that defeated efforts to increase protections for decisionally-impaired research subjects in 1982<sup>62</sup> are being overtaken in 1998.<sup>63</sup> But, rather than rush to change the research system prematurely, ethical analysis must continue while empirical studies progress in refining methods of ascertaining which research subjects need which kinds of enhanced protections.

*Capacity to Give Consent to Research: Reinterpreting the Ethical Arguments*

Just as empirical investigation of assessment of capacity to give consent to research participation is in its infancy, so too is scholarly analysis of the ethics of assessment. Like the majority of empirical studies, the majority of scholarly ethical analyses address the concern of what protections ought to be in place when involving persons already lacking capacity. Only very recently has there been explicit ethics discussion of the need for more research into how best to assess capacity.<sup>64</sup>

While much of the recent ethics literature about decisionally-impaired persons in research has called for increasing protections,<sup>65</sup> concerns about discrimination have served as one of the two countervailing arguments for many years.<sup>66</sup> The discrimination argument holds that if special protections are placed on research participation of decisionally-impaired persons, such protections will disproportionately single out psychiatric research subjects and exacerbate the stigmatization they already experience.<sup>67</sup>

Applying a principlist analysis, the discrimination argument has been vigorously and well argued on grounds that it upholds the basic

62. See Bonnie, *supra* note 5, at 107-108.

63. See *T.D. v New York Office of Mental Health*, 650 N.Y.S.2d 173 (N.Y. App. Div. 1996) (striking down the state health regulations as providing inadequate procedural safeguards for decisionally impaired patients), *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).

64. See WHITE, *supra* note 8, at xi; see also DeRenzo, *The Ethics of Involving Psychiatrically Impaired Persons in Research*, *supra* note 5, at 3; NBAC testimony of Paul S. Appelbaum, *supra* note 8, at 118.

65. See, e.g., Berg, *supra* note 5; Delano & Zucker, *supra* note 5; DeRenzo, *supra* note 4; High et al., *supra* note 5; Keyserlingk, et al., *supra* note 5.

66. See Bonnie, *supra* note 5, at 108.

67. See *id.*

ethical principles of beneficence, nonmaleficence and justice.<sup>68</sup> Not exacerbating existing stigmatization of psychiatrically ill persons avoids further harming this group and in so doing, advances the good. Not singling out psychiatrically ill research subjects upholds the principle of justice by assuring that these subjects are not treated differently from others, where similar treatment is interpreted as equity and fairness. Given that the *Belmont Report*<sup>69</sup> is built on a principlist framework, applying a principlist argument against added protections for research participation of decisionally-impaired persons has been persuasive.

Although this argument has held up for many years, there are now newer ethical analysis strategies that may better account for the many facets of the argument. Casuistry,<sup>70</sup> clinical pragmatism,<sup>71</sup> and feminist ethics approaches<sup>72</sup> have been added to the ways in which ethical problems in medical research can be analyzed since the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research wrote the *Belmont Report*.<sup>73</sup> Where decisionally impaired persons are involved in research, and especially where assessment of capacity is an issue, a feminist ethics analysis,<sup>74</sup> added to a principlist approach,<sup>75</sup> addresses more fully the underlying considerations that influence this area of research.

From a feminist perspective, framing avoidance of discrimination of psychiatrically ill persons as a way to uphold the principle of nonmaleficence also avoids explicit discussion of clinically and morally relevant facts about psychiatric disease. It is simply a matter of clinical reality related to disease

68. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 418 (1994).

69. THE NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH* (1979).

70. See BEAUCHAMP & CHILDRESS, *supra* note 68, at 92-97.

71. See generally Joseph J. Fins et al., *Clinical Pragmatism: A Method for Moral Problem Solving*, 7 KENNEDY INST. ETHICS J. 129 (1997).

72. See generally Evan Gaines DeRenzo & Michelle Strauss, *A New Model of Clinical Ethics Case Consultation: Adding a Feminist Ethics Filter*, 9 HEC FORUM 3, 212-27 (1997).

73. NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 69.

74. See generally S.L. BARTKY, *Femininity and Domination: Studies in the Phenomenology of Oppression* (1990); S. HARDING, *THE SCIENCE QUESTION IN FEMINISM* (1986); HELEN B. HOLMES & LAURA M. PURDY, *FEMINIST PERSPECTIVES IN MEDICAL ETHICS* (1992); ROSE-MARIE TONG, *FEMINISM AND FEMINIST ETHICS* (1993); Maggie O. Little, *Why a Feminist Approach to Bioethics?* 6 KENNEDY INST. ETHICS J. 1 (1996).

75. See Dresser, *supra* note 5, at 67-68.

process that many persons with psychiatric disease can be expected to have impaired mental function:

Dealing with subjects whose decision-making capacities may be impaired (or, in legal terms, who may be incompetent to consent to participate in research) is not an issue unique to psychiatric research. Investigators recruiting non-mentally ill geriatric, adolescent, and seriously medically ill subjects all must be concerned with whether their subjects have adequate capacities to offer valid consents. But it is difficult to avoid the conclusion that psychiatric disorders, which by definition affect mentation, raise special concerns.<sup>76</sup>

Decisional impairments are a frequent by-product of many diseases and conditions. In psychiatric conditions, however, (as well as other diseases and conditions that harm the brain, such as Alzheimer's disease) the decisional impairment is a central feature of the diagnosis. This is simply clinical fact related to these specific conditions and resistance to acknowledging it as such is no longer morally defensible.

Further, what is discriminatory about a psychiatric disease is having it. Adding necessary protections so that the sequelae of the disease do not leave the patient or subject open to harmful manipulation is a regulatory and moral requirement.<sup>77</sup> These protections, however, need to be developed in a way that does not further burden persons who have psychiatric illness, including creating unreasonable barriers to access to innovative research interventions.

A feminist ethics analysis brings into focus more sharply than a principlist approach how issues related to power differentials influence the ethical terrain of the medical research environment.<sup>78</sup> First, even with the most decisionally intact, strong-willed, research-savvy subject, there is a power differential between patient-subject and investigator, regardless of whether the investigator is a physician, nurse, social worker or social scientist. Invariably, the researcher is on top, and the patient-subject is on the bottom.

This power differential is a manifestation of the subject being weakened by disease and the researcher having a superior grasp of the relevant knowledge base.<sup>79</sup> This power differential is a fact of human

---

76. NBAC testimony of Paul S. Appelbaum, *supra* note 8, at 118.

77. See THE NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 69, at 4.

78. See BRODY, *supra* note 55, at 12 (arguing that notions of "power" need to inform medical ethical thinking).

79. See *id.* at 15-16.

psychology within the clinical research setting that needs to be acknowledged, not necessarily as bad, but merely as one of many complexities of the performance of human subjects research that needs to be considered and addressed adequately to ensure appropriate subject care and protection.<sup>80</sup>

The sicker and more debilitated the subject, the greater the power differential.<sup>81</sup> This is not a function of nefarious intent. Nor is it a demonstration that research with sick patient-subjects is inherently coercive. What is inherently coercive is the disease or condition, itself.<sup>82</sup> This phenomenon is as true in research as it is in clinical medicine. Serious disease produces desperation.<sup>83</sup> And while this desperation - both on the part of subjects and their families - can make persons vulnerable to manipulation, there needs to be precision about the source of the vulnerability. In so doing, defensiveness on the part of researchers can be reduced, and appropriate and necessary protections can be developed and implemented.

One reason it is crucial that this power differential be acknowledged in a straight forward manner is that such acknowledgment may work to reduce the psychological discomforts that result from an unarticulated association of the appropriate power of knowledge-holders with the inappropriate abuse of power. Conflating the two concepts acts as a disincentive for open and productive conversation between researchers and research ethicists and fuels the radical elements within community advocacy groups. This in turn results in truly harmful constraints on necessary and appropriately designed studies.<sup>84</sup> That power can devolve to abuse of power goes without saying. That power can be equalized in research is probably a practical impossibility and may not, in fact, be wise.<sup>85</sup> But masking the practical realities prevents us from learning new ways to appropriately manage these power dynamics and adjust our procedures accordingly.

Attention to power issues can also help to break the impasse related to concerns about the effect that additional protections might

---

80. See *id.* at 12.

81. See *id.* at 15.

82. See Nancy E. Kass et al., *Trust: The Fragile Foundation of Contemporary Biomedical Research*, 26 HASTINGS CENTER REP. 25, 25-29 (1996).

83. See *id.* at 25.

84. See *T.D. v. New York State Office of Mental Health*, 650 N.Y.S.2d 173, 186 (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).

85. See EDMUND D. PELLEGRINO & DAVID THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* 35 (1988).

have on the physician-investigator/patient-subject relationship.<sup>86</sup> Resistance to considering novel protections for decisionally-impaired research subjects has often been couched in terms of threats to the integrity of the doctor-patient relationship.<sup>87</sup> But like the weaknesses in the discrimination argument, resistance to change framed in terms of threats to the integrity of the doctor-patient relationship is ill advised.

First of all, the classical construct of the doctor-patient relationship is a function of the clinical world, not the research setting. Although the advent of managed care in clinical practice has severely diminished and distorted the integrity of the traditional doctor-patient relationship, for purposes of the present discussion, let us take the classical doctor-patient relationship as our image of clinical care. In clinical medicine, the doctor-patient relationship is understood to retain its classic form of a one-to-one, private relationship. Such is not the case in medical research.

The physician-investigator/patient-subject relationship is neither private nor one-to-one. The physician-investigator, although the person ultimately responsible on the research team, may hardly get to know the patient-subject. Consent may be obtained by research nurses, fellows, or non-physician associate investigators. In fact, recruitment may begin well before the patient-subject ever arrives at the research center or meets anyone on the research team. Finally, the primary goal of research medicine — advancing knowledge — makes the relationship between a physician-investigator and a patient-subject qualitatively different from the classic clinical medicine relationship between doctor and patient.

Ethical conduct of research demands a straightforward acknowledgment of the differences in the relationship of physician-investigator to patient-subject and that of doctor to patient.<sup>88</sup> Acknowledgment of these differences, however, ought not be misconstrued as pejorative. Again, feminist ethics has important insights to offer.

Historically, women's moral reasoning has been considered inferior because it is different from men's.<sup>89</sup> The work of Carol Gilligan,

---

86. See Kathryn M. Taylor & Merrijoy Kelner, *Informed Consent: The Physicians' Perspective*, 24 SOC. SCI. MED. 135, 140 (1987).

87. See generally Bonnie, *supra* note 5.

88. See Larry R. Churchill, *Physician-Investigator/Patient-Subject: Exploring the Logic and the Tension*, 5 J. MED. & PHIL. 215, 220 (1980).

89. See, e.g., Sigmund Freud, *Some Psychological Consequences of the Anatomical Distinction between the Sexes*, in THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD (James Strachey trans. & ed., stand. ed. 1925); LARRY KOHLBERG, THE PHILOSOPHY OF MORAL DEVELOPMENT

however, began changing that view to one in which there is an appreciation that, in fact, women do use different moral reasoning processes than men and that these different processes result in moral reasoning of equally high quality.<sup>90</sup> We should translate this lesson into the research setting and end the tradition of demeaning the physician-investigator/patient-subject relationship as less ethically motivated than the doctor-patient relationship. Both are moral relationships; they simply are different relationships. By appreciating the moral validity of the physician-investigator/patient-subject relationship, we free our creative capabilities to more openly address the complexities inherent in the research setting and develop and implement appropriate management strategies.

Finally, the feminist ethics acceptance of power as a legitimate point of ethical inquiry directs us to examine the invisible ways in which fear of loss of power influences the debates around how best to protect decisionally-impaired persons in research. "The temptation for those involved in psychiatric research to see questions about their practices as troublesome impediments to advancing knowledge ought to be resisted."<sup>91</sup> But the temptation to resist what may be felt as a threatening intrusion is great when one fears that such intrusion will result in loss of power and loss of research subjects.

An example is resistance to changes in how assessment of capacity is conducted. The suggestion that assessment of capacity be conducted by a person or persons independent of the research team<sup>92</sup> produces struggles over who is in control of the process and why each person's view should prevail. These power struggles are primarily between those who have traditionally been responsible for capacity assessment (*i.e.* physicians [usually psychiatrists]) and those who are suggesting that the process might be enhanced by independent capacity assessment (*i.e.* bioethicists, patient advocates, and lawyers).

Suggestions that independent assessment is needed to compensate for lack of objectivity and a weakening of an overriding concern

---

(1981); SUSAN SHERWIN, *NO LONGER PATIENT: FEMINIST ETHICS AND HEALTH CARE* 43 (1992); ELIZABETH V. SPELMAN, *INESSENTIAL WOMAN: PROBLEMS OF EXCLUSION IN FEMINIST THOUGHT* 6 (1988).

90. See CAROL GILLIGAN, *IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S MORAL DEVELOPMENT* 105 (1982) (Based on three similar studies, the author throughout reflects a central assumption within her research: that the way people talk about their lives is of significance, that the language they use and the connections they make reveal the world that they see and in which they act.).

91. See Paul S. Appelbaum, *Rethinking the Conduct of Psychiatric Research*, 54 *ARCHIVES GEN. PSYCHIATRY* 117, 199 (1997).

92. See DeRenzo, *supra* note 4, at 21-22.



for the welfare of the person threatens the physician-investigator *qua* physician. The same suggestion threatens the physician-investigator *qua* investigator by implying that more subjects will be assessed not-capacitated and thereby rendered ineligible for study enrollment. Although these are legitimate concerns, they must be openly discussed and systematically studied. That introduction into the consent process of disinterested third parties will result in loss of power or research subjects is a factual belief, not a fact. We simply have no data about these issues. But while we await such useful data to be generated, keeping these concerns hidden and invisible assures that creative or constructive thinking about these matters will be constrained.

The final and forceful argument that has served as a successful barrier to development and implementation of additional protections for decisionally-impaired persons in research is that additional rules and protective mechanisms will inappropriately slow down the progress of science. Here, too, this argument can no longer be unquestioningly defended. Although no systematic study has been conducted to gather data to support or refute this position, there is documented experience with at least one protocol indicating that the supposition was not sustainable in that case.

A research study investigating brain glucose metabolism in Alzheimer's Disease, presently being conducted at the National Institutes of Aging (NIA), includes in its study population subjects in the advanced stages of Alzheimer's Disease and Down Syndrome who have severe decisional impairments.<sup>93</sup> When initially presented to the NIA's Institutional Review Board (IRB), the protocol was written to allow persons to be eligible for enrollment by a surrogate if that surrogate was appointed through the documentation of an ethically and legally valid Durable Power of Attorney for Health Care (DPA), as permitted by existing National Institutes of Health policy.

All on the IRB agreed that the protocol should be designated no-expected-direct benefit, greater-than-minimal-risk. All agreed, also, that the study was of significant import, was well designed, and could not be conducted without severely decisionally-impaired subjects. The IRB, however, did not agree that just any DPA was adequate. Instead, the IRB required that unless the existing DPA specifically documented willingness to participate in research, the DPA was not sufficient to allow for surrogate enrollment.

---

93. DeRenzo was a member of the NIA's IRB when this protocol was presented, passed, and reviewed on continuing review for the first 3 years of the protocol's performance.

At that time, the opposing argument was grounded in the consequentialist proposition that such a restriction on subject enrollment would so constrain subject accrual as to inappropriately slow down the study. That hypothesis has been refuted. As the protocol has been re-reviewed annually by the IRB, the investigators have reported that the restriction has not slowed or had any other deleterious effect on subject accrual or other aspects of study progress.

This information, along with the reinterpretation of the ethical arguments that have to date impeded progress in developing novel protections for decisionally impaired persons in research, juxtaposed against the advent of radical court decisions<sup>94</sup> and, these authors hope, sound and useful state legislation, suggests that the time has come to break down barriers to collaborative discussion. For it is only through thoughtful, open, and collaborative discussion that there is hope of real improvement in how the ethical sensitivities presented by biomedical and social science research involving decisionally-impaired persons can take hold.

#### *Empirical Research Presently Underway*

While the debates continue in public, professional, legislative, and judicial fora, empirical studies are slowly progressing. The authors, with the addition of other colleagues, have recently completed the first series of studies investigating a novel consent education design and a standardized clinical assessment tool. The first study,<sup>95</sup> examined whether or not the Evaluation to Sign Consent (ESC) form could be used to discriminate between those persons who were and were not sufficiently capacitated to provide ethically and legally valid consent.<sup>96</sup>

The ESC is a tool for assessing a subject's factual understanding of information required to provide ethically valid consent to participate in a specific research study.<sup>97</sup> In the aforementioned study, after a variable period of education about the research study to which the psychiatric patient was going to be asked to consent to join,<sup>98</sup> but

---

94. 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).

95. See Robert R. Conley et al., *Evaluating Ability to Consent to Schizophrenia Research* (unpublished data, on file with authors, Robert Conley & Evan DeRenzo).

96. The ESC was developed by Raymond Love, Pharm.D., University of Maryland, School of Pharmacy in 1988 for the purpose of evaluating the ability of people to consent in practical clinical situations.

97. See Conley et al., *supra* note 95, at 3.

98. See *id.* at 10.

before the formal consent process was initiated, the ESC was administered to the prospective subject by a psychiatrist or research nurse independent of the research team.<sup>99</sup> If the prospective subject scored all five questions correctly, the prospective subject would then be eligible to enter into the formal consent process, conducted by the Principle Investigator (Conley) of the primary research study, a randomized, double-blind drug trial.<sup>100</sup>

The ESC's first systematic use was in 1990 in a study of twenty-four subjects in a randomized, double-blind drug trial.<sup>101</sup> In that early experience with the ESC, the majority of subjects (16/24) failed the assessment.<sup>102</sup> To increase ability to provide ethically and legally valid consent, the consent education groups were initiated.<sup>103</sup> The sixteen subjects who did not pass the ESC initially entered the group.<sup>104</sup> Subjects were tested every two weeks with the ESC.<sup>105</sup> Four subjects passed at week 2, eight at week 4, one at week 6, two at week 8 and one at week 16.<sup>106</sup> Subjects were not re-tested in this study after they passed the ESC.<sup>107</sup>

A new study for which data are now being analyzed by the authors asks the questions: Do psychiatric research subjects retain their capacity to provide consent throughout study participation as measured by the ESC? If they do, is there a relationship between capacity to consent and participation in a weekly education group?<sup>108</sup> Preliminary analysis of the data from this second study indicates that subjects, in the main, do retain their ability to provide ethically and legally valid consent as assessed by the ESC.<sup>109</sup> In this study, as in the study just analyzed,<sup>110</sup> the majority of subjects passed the ESC assessment evaluation.

At the same time these studies have been proceeding, Paul Appelbaum and his research group have collaborated with Conley and his colleagues at the University of Maryland Medical School, as well as researchers at the University of Virginia and the University of Pitts-

---

99. *See id.* at 11.

100. *See id.* at 10.

101. *See* Conley et al., *supra* note 95 (unpublished data, on file with co-author, Robert R. Conley).

102. *See id.*

103. *See id.*

104. *See id.*

105. *See id.*

106. *See id.*

107. *See id.*

108. Unpublished data, on file with authors.

109. *See id.*

110. *See* Conley et al., *supra* note 95.

burgh, to evaluate the usefulness of the standardized assessment tool used for evaluating capacity to give research consent that Appelbaum and his colleagues have developed. This tool is the MacArthur Competence Assessment Tool - Clinical Research (MacCAT-CR). In his presentation to the National Bioethics Advisory Commission (NBAC) on July 15, 1997, Appelbaum presented preliminary findings from the three sites where the MacCAT-CR is being tested.<sup>111</sup> He reported to the NBAC that the majority of subjects at the University of Maryland and at the University of Virginia failed the assessment but the majority of subjects at the University of Pittsburgh passed.<sup>112</sup>

Both instruments appear to have some utility. Both, however, are only initial attempts at what will require steady and refined study if a truly valid and reliable assessment-of-capacity-to-give-consent-to-research tool is to be successfully developed and widely used. We see these two assessment tools as book ends to a process that promises to eventually produce a solid assessment instrument. Such an instrument is badly needed.

There is a general consensus that ethically and legally valid consent requires at least an ability to express a choice, understanding of the relevant information, voluntariness, and appreciation of the situation and its possible consequences.<sup>113</sup> How one operationalizes these requirements, however, has yet to be determined. To date, assessment has been made on clinical indicators, and we already have evidence that clinical judgment is not enough. For some time, data have been available demonstrating that when clinical judgment alone is compared to evaluation, including standardized instruments and scales, a wide range of mental and physical problems and diagnoses are missed with clinical judgment alone.<sup>114</sup>

To the best of the authors' knowledge, the ESC and the MacCAT-CR are the only two assessment-of-capacity-to-give-consent-to-research tools in the testing phase. Both show promise. Both, however, also have their shortcomings.

The ESC is a five-item questionnaire designed to evaluate a prospective or on-going subject's factual comprehension of information relevant to participation in the actual study for which the subject is being considered or in which the subject is already participating. The

---

111. See NBAC testimony of Paul S. Appelbaum, *supra* note 8, at 4.

112. See *id.*

113. See generally 45 CFR § 46; NBAC testimony of Paul S. Appelbaum, *supra* note 8, at 119.

114. See Ellen M. Pinholt et al., *Functional Assessment for the Elderly: A Comparison of Standard Instruments with Clinical Judgment*, 147 ARCHIVES INTERNAL MED., 484, 486 (1987).

MacCAT-CR is a twenty page questionnaire that poses questions about a hypothetical study. The ESC is short and concrete, asking only about study-specific facts. The MacCAT-CR is much longer and abstract, asking questions about which there is philosophic disagreement in the research and research ethics communities.<sup>115</sup> The ESC may not be sufficiently rigorous. The MacCAT-CR may be setting a standard higher for persons with psychiatric disease than for physician-investigators and bioethicists. When all the testing is over, it is highly likely that the ESC will be deemed too easy to pass and the MacCAT-CR deemed too difficult.

There is also another instrument that has the potential for application to the research setting given appropriate modifications. The AID to Capacity Evaluation (ACE),<sup>116</sup> although created for clinical practice, appears to be amenable to adaptation to the research setting.<sup>117</sup> The ACE, developed at the Joint Center for Bioethics at the University of Toronto, is approximately the length of the ESC. It is short and concrete and asks questions about the patient's actual situation, but with a more complex scoring and evaluation system than either the ESC or the MacCAT-CR. This instrument, like the ESC and the MacCAT-CR, has strengths and weakness and offers insights into the assessment testing process that may be usefully incorporated into an instrument that ultimately meets the challenge. In the meantime, the time-consuming process of clinical research designed to yield such an instrument continues.

*Conclusion: Charting a Course for Future Research and Debate*

Many more studies and open discussions will be required if we are to better understand how to assess an individual's capacity to provide ethically and legally valid consent. As such research and discussions progress towards development of a standardized assessment instrument, we must be careful not to make changes in the research process prematurely. Although it is clear that we need better understanding of what capacities are required for an individual to be able to provide fully informed consent, and we need better and more open

---

115. For example, subjects are asked to make distinctions between direct-benefit and no-direct benefit research that are points of controversy in the research ethics community.

116. See Edward Etchells et al., *Accuracy of Clinical Assessments of Patient Capacity to Consent to Treatment*, 114 J. GEN. INTERNAL MED. 114, 114 (1996); Edward Etchells et al., *Bioethics for Clinicians: 3. Capacity*, 155 CANADIAN MED. J. 657, 659 (1996).

117. Electronic mail and letters from Ed Etchells, MD, MSC, Asst. Prof. Dept. of Med., University of Toronto (September, 1997).

ways of assessing those capacities, we ought not rush ahead without first having sound information upon which to base any changes.

In urging prudence in how we make changes, we return to the discrimination argument, considering it in its broadest sense. We agree that protections related to research participation with decisionally-impaired persons will, and should, focus heavily on persons with psychiatric diseases. We argue this point on the clinical grounds that many psychiatrically ill persons will have impaired decisional capacities, as we discussed earlier in this article in greater detail. Thus, we interpret the principle of justice, in the case of decisionally-impaired persons, to require that persons be provided that which they need and deserve. That is, we accept that persons with decisional impairments may require different and greater protections than those who do not have such impairments, a point made clearly in the *Belmont Report's* explanation of how we treat persons with respect.<sup>118</sup> By treating persons in different ways fair treatment of all can better be assured.

But rushing is likely to produce harmful unintended consequences rather than merely improved process. Without careful study and incremental implementation of well-designed change, seemingly useful changes may, in fact, result in adding greater burdens to an already burdened group — a grave injustice indeed. An example familiar to all will demonstrate the possibilities.

Deinstitutionalization of the mentally ill was heralded as a panacea. But there were no sound data at the time the Mental Retardation Facilities and Community Mental Health Centers Act<sup>119</sup> was passed in 1963.<sup>120</sup> Instead, sweeping changes in the traditional methods of providing clinical care to psychiatrically ill persons were instituted as a result of political momentum, albeit based on legitimate concerns. But regardless of how well-placed those concerns were, sufficient data about how to go about making such sweeping changes in a way that helped, and did not harm those affected were lacking. Today, the plight of many homeless persons is a palpable reminder of the miseries that come of change brought about too swiftly, regardless of the underlying good will that motivates it.

Therefore, instead of risking making new errors in how we treat persons made vulnerable by disease and conditions that impair their ability to make their own decisions, let us conduct the research, pains-

---

118. THE NATIONAL COMM'N FOR THE PROTECTION OF HUMAN SUBJECTS OF BIOMEDICAL AND BEHAVIORAL RESEARCH, *supra* note 69, at 4.

119. Pub. L. 88-164, 77 Stat. 282 (codified as amended at 42 U.S.C. § 6000 (1963)).

120. See Richard Jed Wyatt & Evan G. DeRenzo, *Scienceless to Homeless*, 234 SCIENCE 1309 (1986).

taking, expensive and time-consuming as it may be, in an effort to develop the knowledge and standardized tools needed to more adequately measure ability to provide consent to research participation. Simultaneously, the research, research ethics and advocacy communities must hold the kind of open and thoughtful conversations that are required to allow us all to use knowledge, gained wisely, in advancing the well being of decisionally-impaired persons. For while it may be true that such persons are in need of novel mechanisms for assuring that ethically and legally valid consent can be obtained for their research participation, it is certainly true that such persons need the research into the treatments and cures of their diseases to go forward.