



# Ethical Conflicts in Randomized Controlled Trials

Robert D. Truog, MD

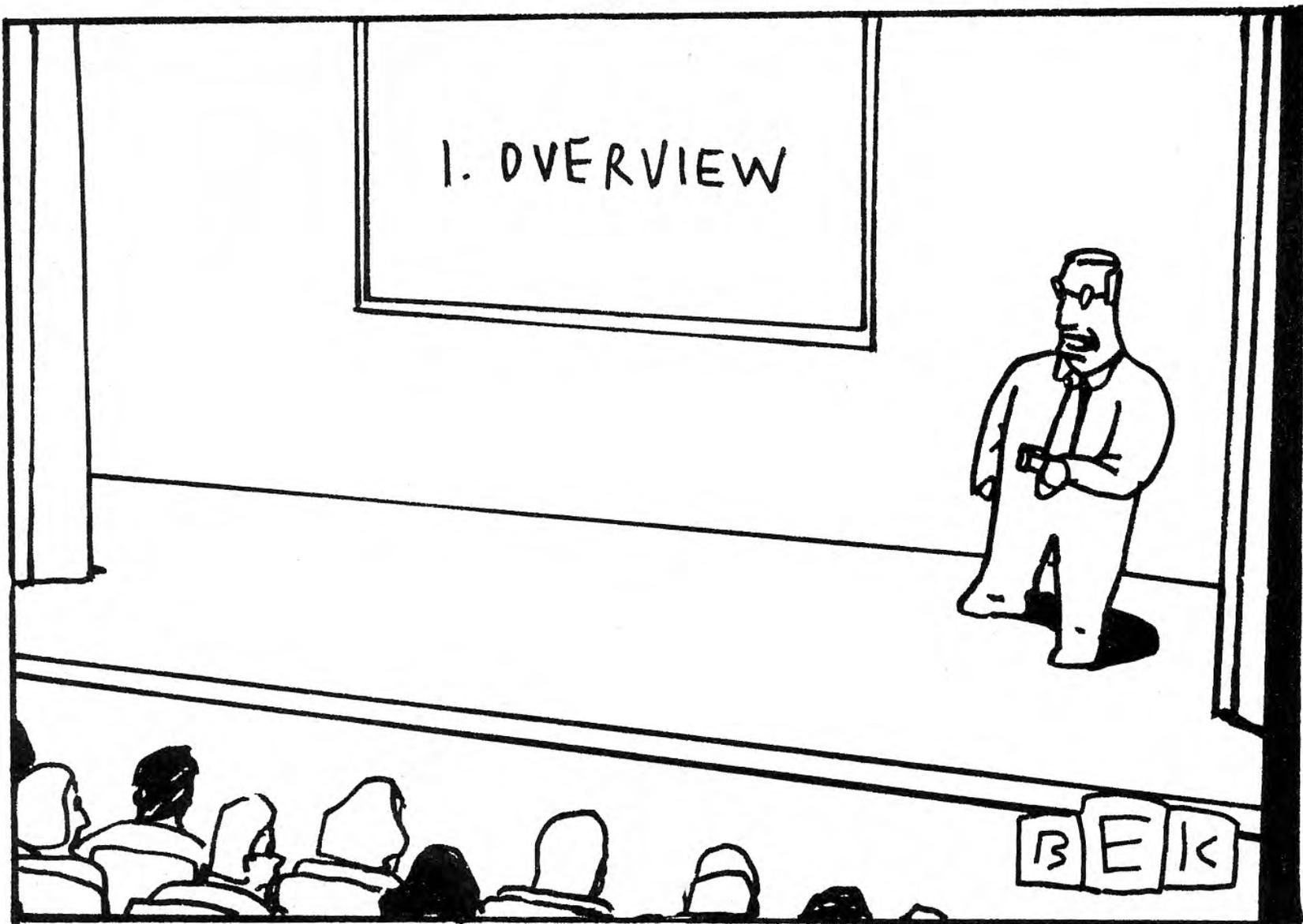
Professor of Medical Ethics, Anaesthesia, & Pediatrics

Director of Clinical Ethics, Harvard Medical School

Executive Director, Institute for Professionalism & Ethical Practice

Senior Associate in Critical Care Medicine,

Boston Children's Hospital



*“First, I want to give you an overview of what I will tell you over and over during the entire presentation.”*

# Overview

- ExtraCorporeal Membrane Oxygenation (ECMO):
  - A Case Study
- Clinician vs Investigator:
  - The Fundamental Conflict
- Adaptive Randomization:
  - Balancing Conflicting Obligations
- Randomized Consent (Zelen Randomization):
  - Easing the Psychological Burdens
- Are RCTs the only way to learn?
  - Ethical boundaries vs statistical certainty

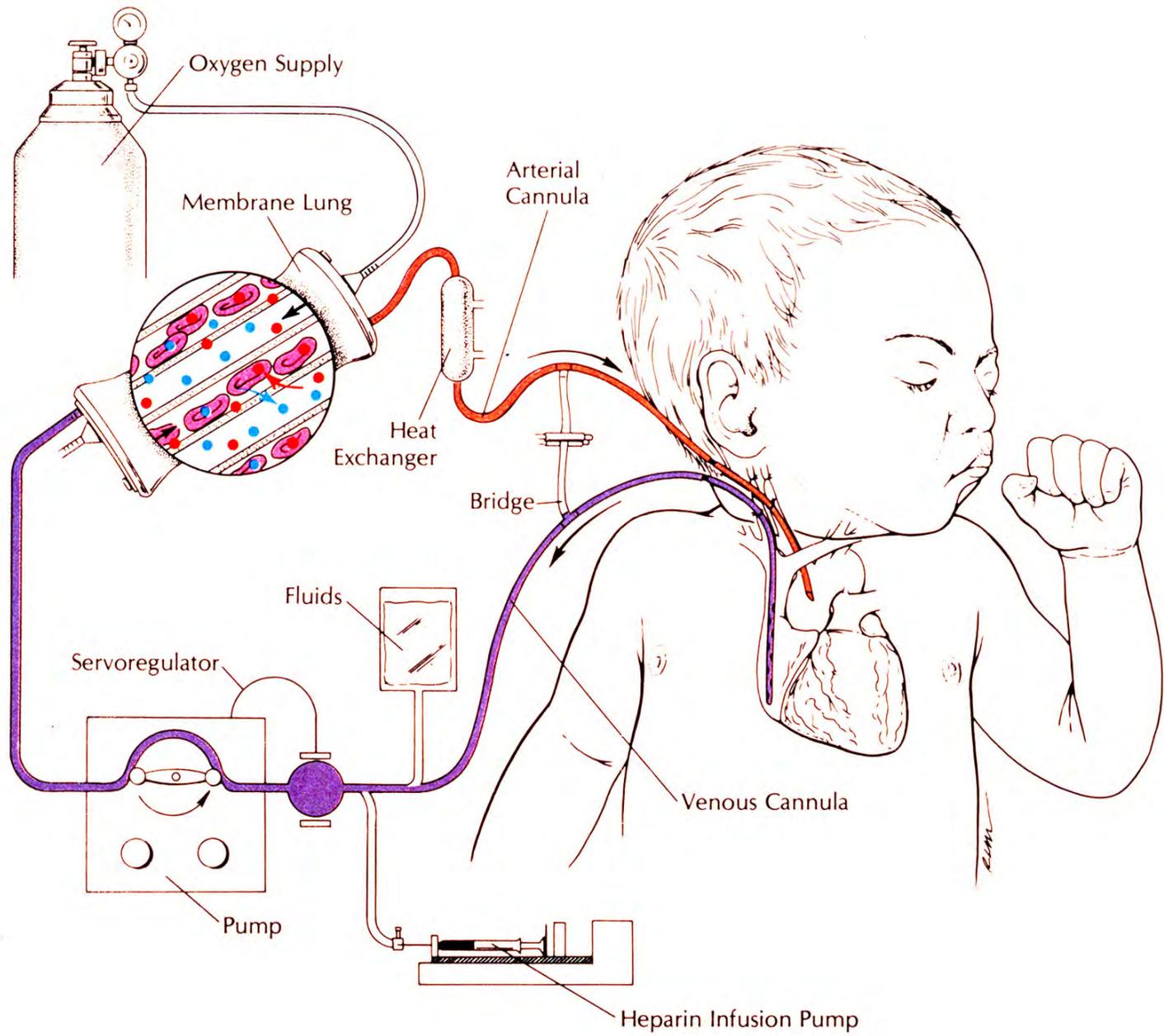
# PEDIATRICS<sup>®</sup>

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## **Extracorporeal Membrane Oxygenation and Conventional Medical Therapy in Neonates With Persistent Pulmonary Hypertension of the Newborn: A Prospective Randomized Study**

**P. Pearl O'Rourke, MD, Robert K. Crone, MD, Joseph P. Vacanti, MD, James H. Ware, PhD, Craig W. Lillehei, MD, Richard B. Parad, MD, and Michael F. Epstein, MD**

**Pediatrics 1989;84:957-63.**







TO COME OFF E.C.M.O.

- A. CLAMP VENOUS LINE.
- B. UNCLAMP BRIDGE.
- C. CLAMP ARTERIAL LINE.
- D. DISCONNECT OXYGEN TUBING FROM TOP OF MEMBRANE.



# Background to the Harvard Trial

- An RCT in the 1970s had shown ECMO not effective for ARDS in adults
- In the 1980s, Robert Bartlett used ECMO to treat newborns with PPHN
- Results were very impressive
- But, pediatricians were reluctant to adopt ECMO without convincing data from an RCT

# Questions

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- Imagine you were Bob Bartlett
- Would you have sought to perform an RCT to demonstrate the superiority of ECMO to Conventional Medical Therapy (CMT)?
- Why or why not?

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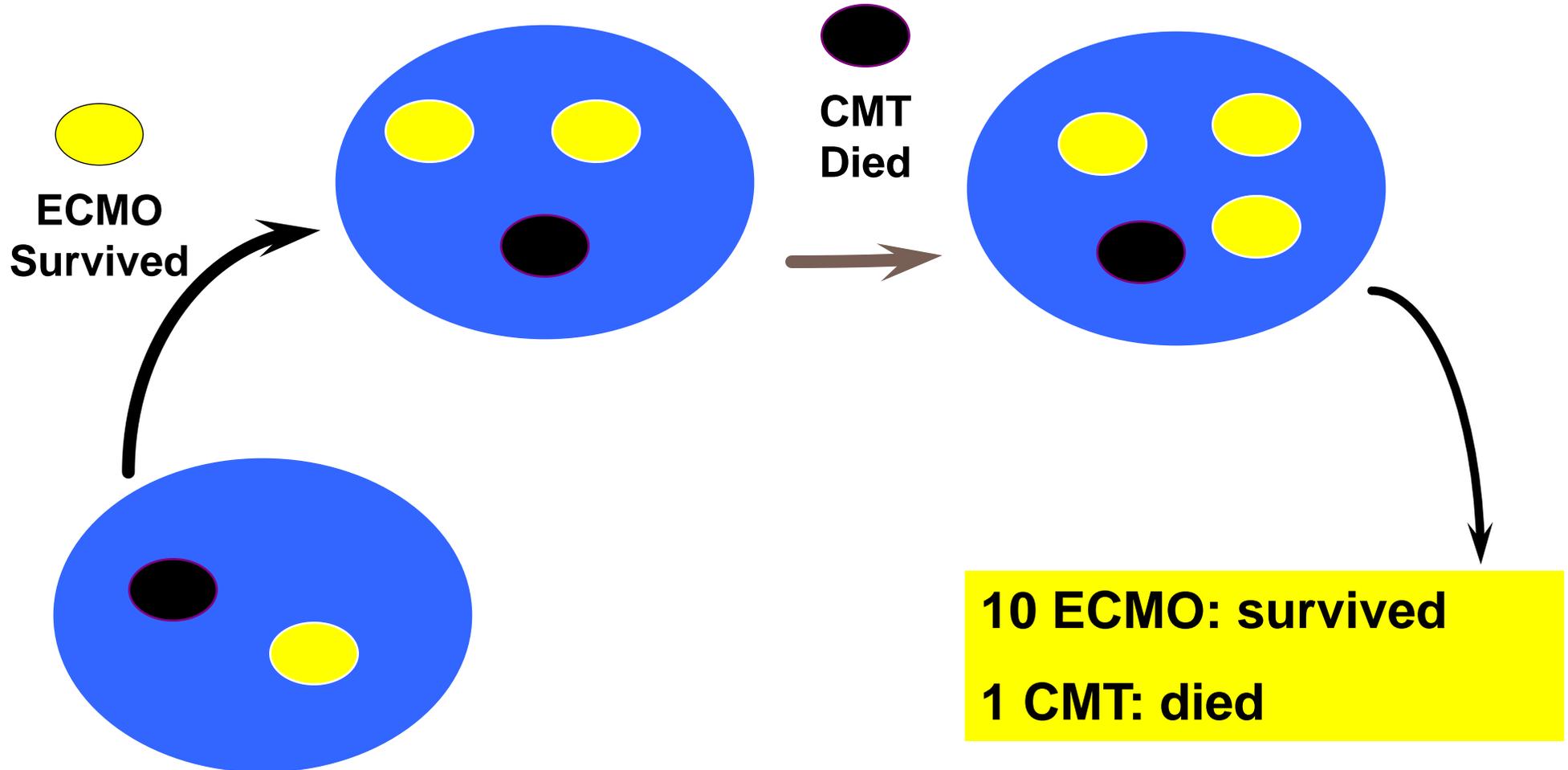
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## **Extracorporeal Circulation in Neonatal Respiratory Failure: A Prospective Randomized Study**

**Robert H. Bartlett, MD, Dietrich W. Roloff, MD, Richard G. Cornell,  
PhD, Alice French Andrews, MD, Peter W. Dillon, MD, and  
Joseph B. Zwischenberger, MD**

**Pediatrics 1985;76:479-87.**

# Bartlett: Play-the-Winner Design



# Questions

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- Imagine you were a neonatologist in Boston
- When you read this article, would you have told your hospital administrator that you needed to start an ECMO program?
- Why or why not?

**Extracorporeal Circulation in Neonatal Respiratory Failure: A Prospective  
Randomized Study**

JAMES H. WARE and MICHAEL F. EPSTEIN  
*Pediatrics* 1985;76;849-851

“The clinical indications for this new and complex treatment remain undefined. Further randomized controlled trials... will be difficult but remain necessary.”

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## **Extracorporeal Membrane Oxygenation and Conventional Medical Therapy in Neonates With Persistent Pulmonary Hypertension of the Newborn: A Prospective Randomized Study**

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# The Harvard Neonatal ECMO Trial

Randomized newborns with PPHN to  
conventional therapy versus ECMO

## Conventional Therapy

**NICU: 7th Floor**

**Neonatologists**

**No patients had ever  
been offered ECMO**

**Anti-ECMO**

## ECMO

**PICU: 5th Floor**

**Anesthesiologists &  
Surgeons**

**Already had experience  
with ECMO for newborns  
with CDH**

**Pro-ECMO**

# The Harvard Neonatal ECMO Trial: Study Design

- Eligible newborns had PPHN and a predicted mortality of 85% based upon retrospective data
- Phase I: 50/50 randomization until there are 4 deaths in one arm
- Phase II: Assign all patients to the more successful therapy, until there are 4 deaths in that arm or until statistical significance is achieved
- Seek consent only from those randomized to the experimental therapy (ECMO)

$$P(p_1 > p_2) = \frac{F_1}{F_1 + F_2 + F_3},$$

$$P(p_1 = p_2) = \frac{F_2}{F_1 + F_2 + F_3},$$

$$P(p_1 < p_2) = \frac{F_3}{F_1 + F_2 + F_3},$$

where

$$\begin{aligned} F_1 &= \int_0^1 \int_0^{p_1} p_1^{\alpha-2} (1-p_1)^{b-1} p_1^6 (1-p_1)^4 p_2^9 dp_1 dp_2 \\ &= \int_0^1 p_1^{\alpha+4} (1-p_1)^{b+3} \int_0^{p_1} p_2^9 dp_2 dp_1 \\ &= \frac{1}{10} \int_0^1 p_1^{\alpha+14} (1-p_1)^{b+3} dp_1 \\ &= \frac{1}{10} \frac{\Gamma(\alpha+15)\Gamma(b+4)}{\Gamma(\alpha+b+19)} \end{aligned}$$

and, similarly

$$\begin{aligned} F_2 &= \frac{\Gamma(\alpha+15)\Gamma(b+4)}{\Gamma(\alpha+b+19)}, \\ F_3 &= \frac{1}{10} \left[ \frac{\Gamma(\alpha+6)\Gamma(b+3)}{\Gamma(\alpha+b+9)} - \frac{\Gamma(\alpha+16)\Gamma(b+3)}{\Gamma(\alpha+b+19)} \right]. \end{aligned}$$

# The Harvard Neonatal ECMO Trial: Results

	<b>ECMO</b>	<b>CMT</b>
<b>Phase I</b>	<b>9 s, 0 d</b>	<b>6 s, 4 d</b>
<b>Phase II</b>	<b>19 s, 1 d</b>	



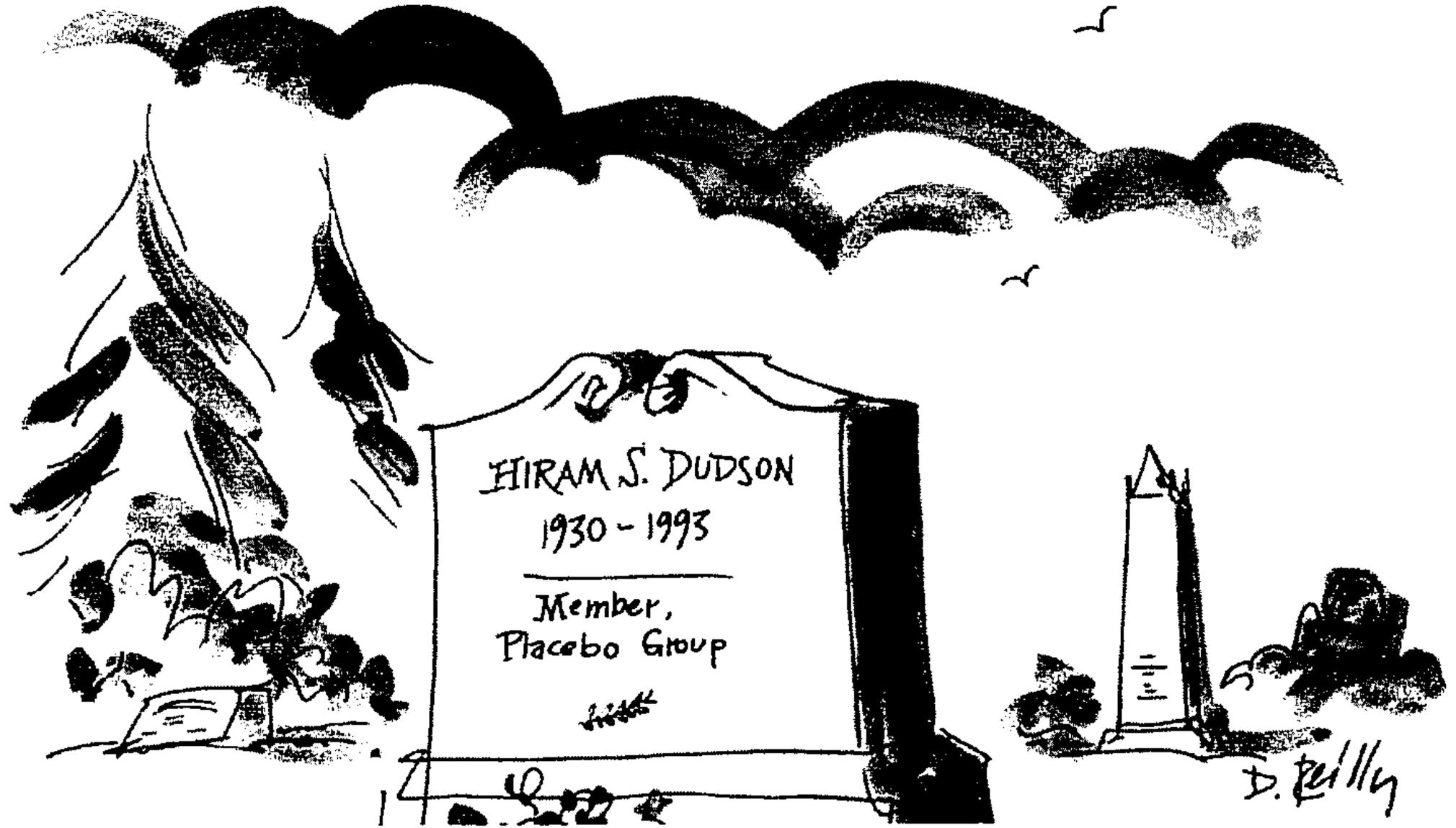
# Healer versus Investigator

**The Fundamental Conflict**

# The fundamental dilemma

- A dilemma confronts physician-investigators...
- As physicians they are dedicated to caring for their patients...
- As investigators they are dedicated to caring for their research...
- These two commitments conflict whenever an individual physician/investigator comes face to face with an individual patient/subject.

Jay Katz, 1993



HIRAM S. DUDSON  
1930 - 1993

Member,  
Placebo Group

D. Kelly

# Possible Solution #1: Full Separation of Roles

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“Researchers must give patients stark, bold, and dramatic signs that research is different from clinical care... instead of the white coats associated with medical care, investigators could wear red ones...”

Dresser R. Soc Philos Policy 2002; 19:271

## Possible solution #2: Personal Equipoise

- Requires that the investigator be personally unbiased between the treatment arms, “perfectly balanced on the edge of the sword”
- But, researchers usually “believe in” the treatments they study
- Requiring personal equipoise leaves investigators feeling either “guilty” or “cynical”

# Possible solution #3: Clinical Equipoise

- Requires uncertainty within the medical community as a whole
  - ▣ “I believe that “A” is better, but if your appointment had been with my colleague down the hall, she would have recommended “B”
  - ▣ “So... would you agree to have your treatment determined by a coin flip, so that we can learn from this experience?”
- Harvard ECMO Trial
  - ▣ Likely that no single investigator was in personal equipoise
  - ▣ Does the collective uncertainty make the research ethical?



# **Adaptive Randomization**

**Balancing Conflicting  
Obligations**

# Adaptive Randomization

- Definition: Deviating from “balanced” or 50/50 randomization, with more patients assigned to the therapy that is “leading” during the trial
- Betting on the horse who is out in front, before we know how the race will end

# Adaptive Randomization: Advantages

- Attempts to mitigate the conflict of healer versus investigator
- Attempts to minimize number of patients assigned to the less-successful therapy
  - ▣ In the Bartlett trial, 50/50 randomization was guaranteed only for the first patient
  - ▣ In the Harvard trial, 50/50 randomization was guaranteed until the 4th death in one arm

# Adaptive Randomization: Disadvantages

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- There must be only one outcome of interest
- The outcome must be apparent within a short period of time
- May suffer from accrual bias: volunteers may want to be recruited into the trial later

# Adaptive Randomization

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- In the literature, the trial was criticized from both directions
  - ▣ No patients should have been assigned to CMT
  - ▣ Not enough patients were assigned to CMT
  
- Perhaps this approach was a good balance

# Adaptive Clinical Trials

## A Partial Remedy for the Therapeutic Misconception?

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William J. Meurer, MD, MS

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Roger J. Lewis, MD, PhD

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Donald A. Berry, PhD

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# Adaptive Trials in Clinical Research

## Scientific and Ethical Issues to Consider

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Rieke van der Graaf, PhD

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Kit C. B. Roes, PhD

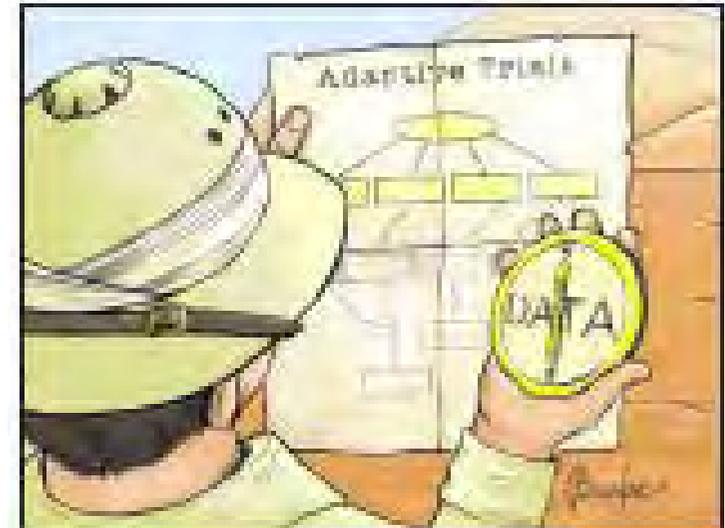
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Johannes J. M. van Delden, MD, PhD

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van der Graaf et al. JAMA 2012;307:2379

Meurer et al. JAMA 2012;307:2377



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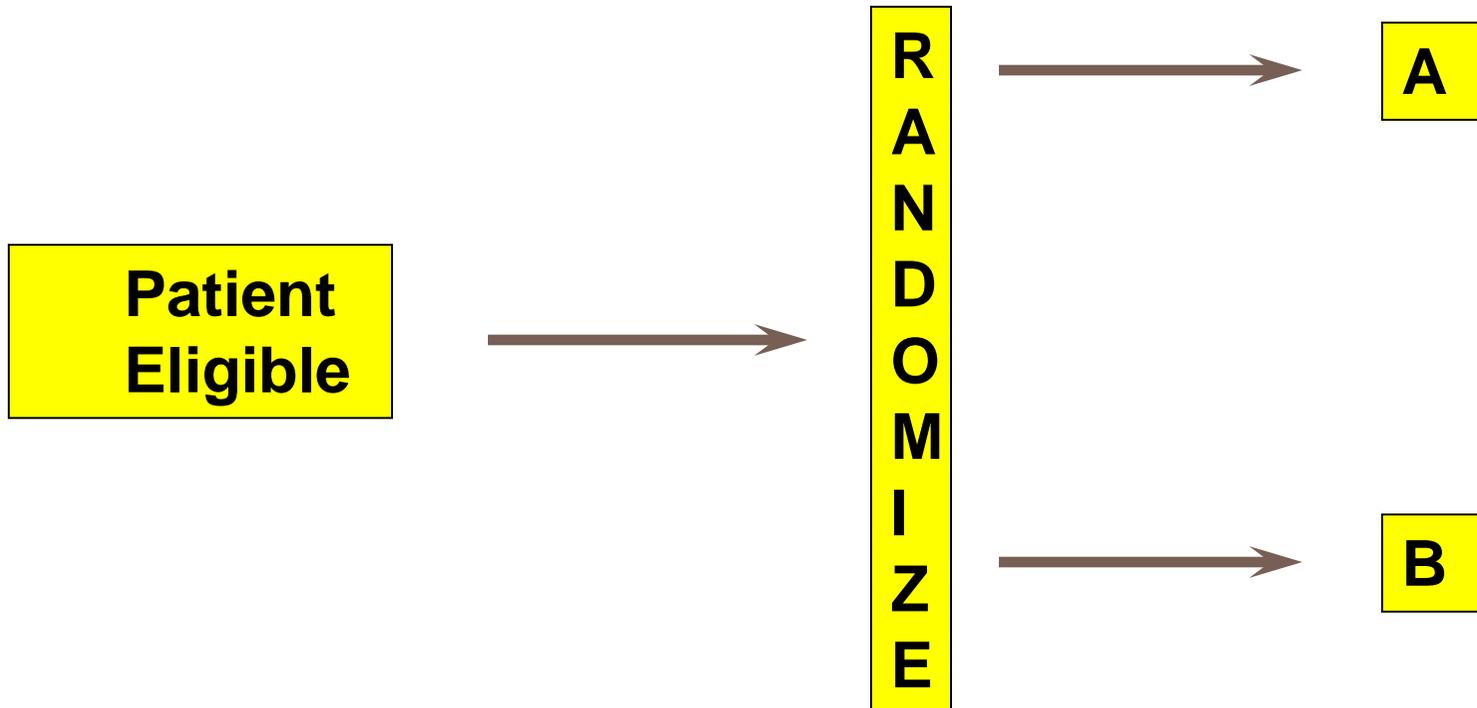


# **Randomized Consent**

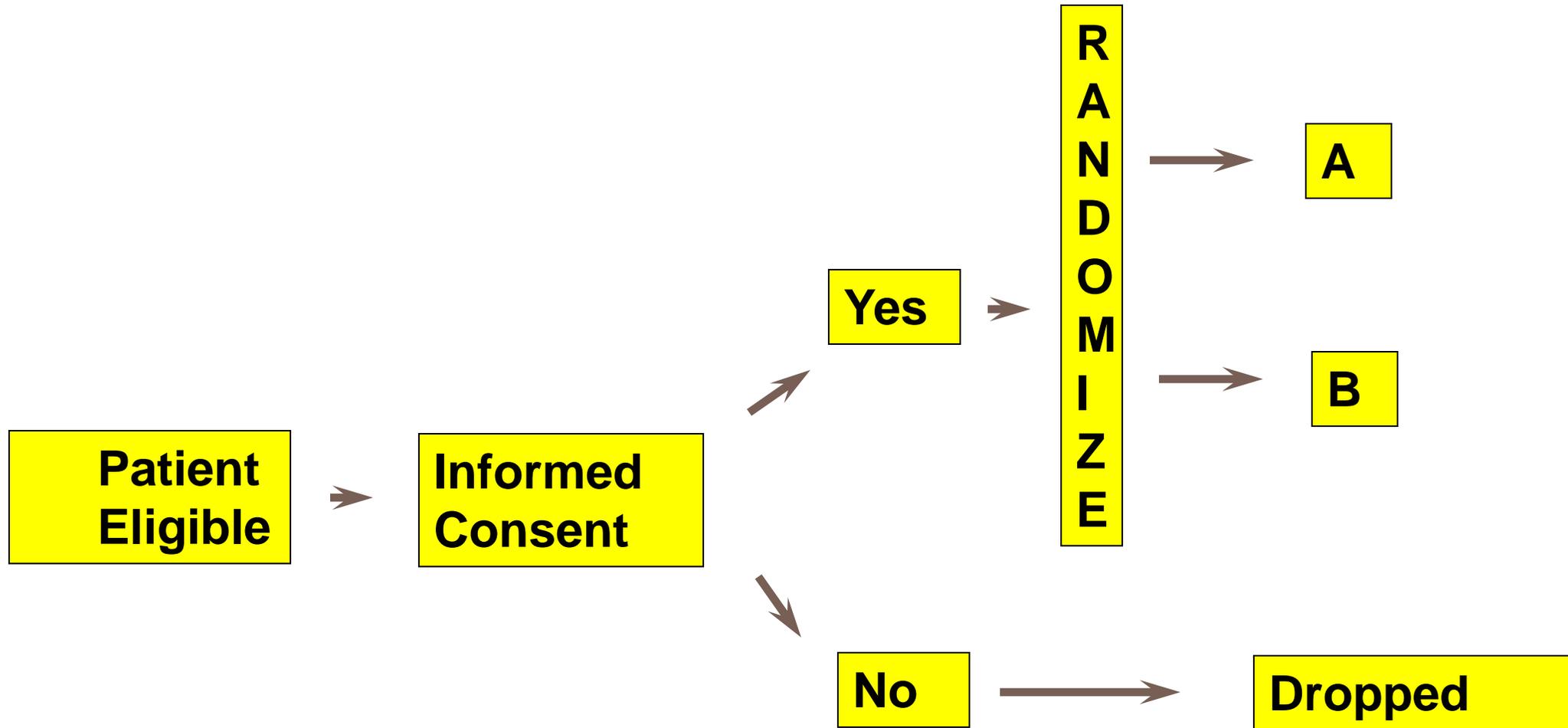
**(Zelen Randomization)**

**Easing the Psychological  
Burdens**

# Conventional RCT, Without Informed Consent



# Conventional RCT, With Informed Consent



**Zelen M. A new design for randomized clinical trials. *New England Journal of Medicine* 1979;300:1242-5.**



**Marvin Zelen**

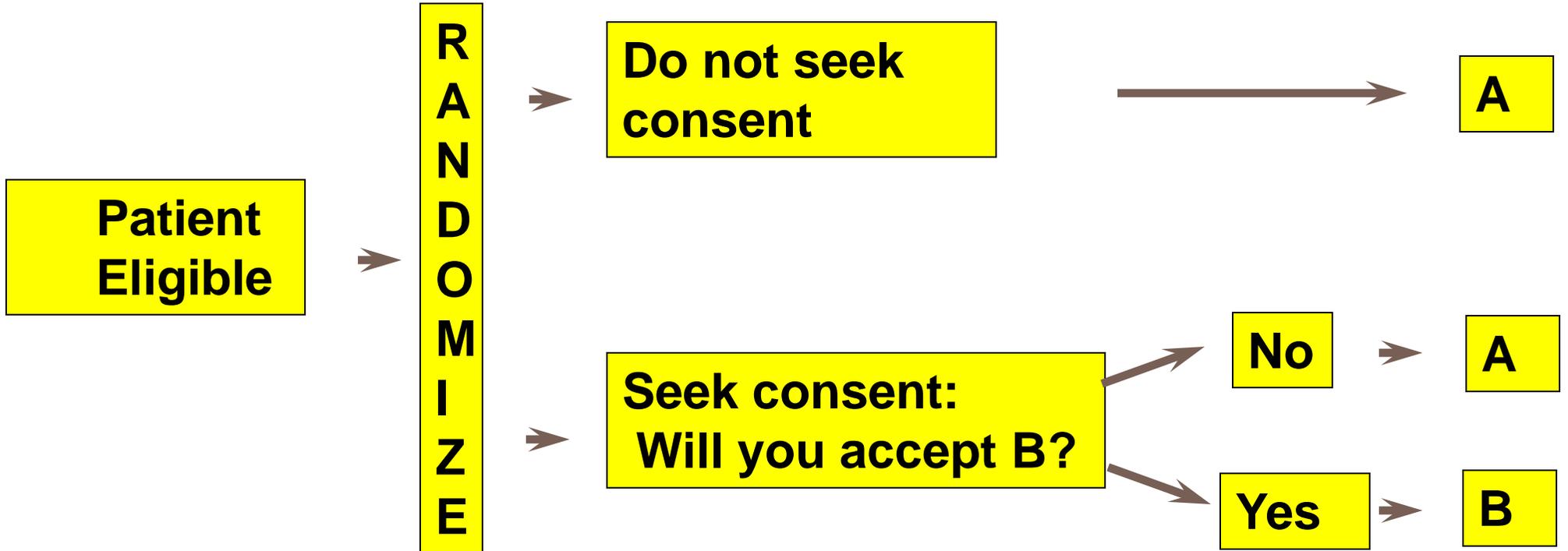
*Lemuel Shattuck Research Professor of Statistical Science and Member of the Faculty of Arts and Sciences*

**Department of Biostatistics**

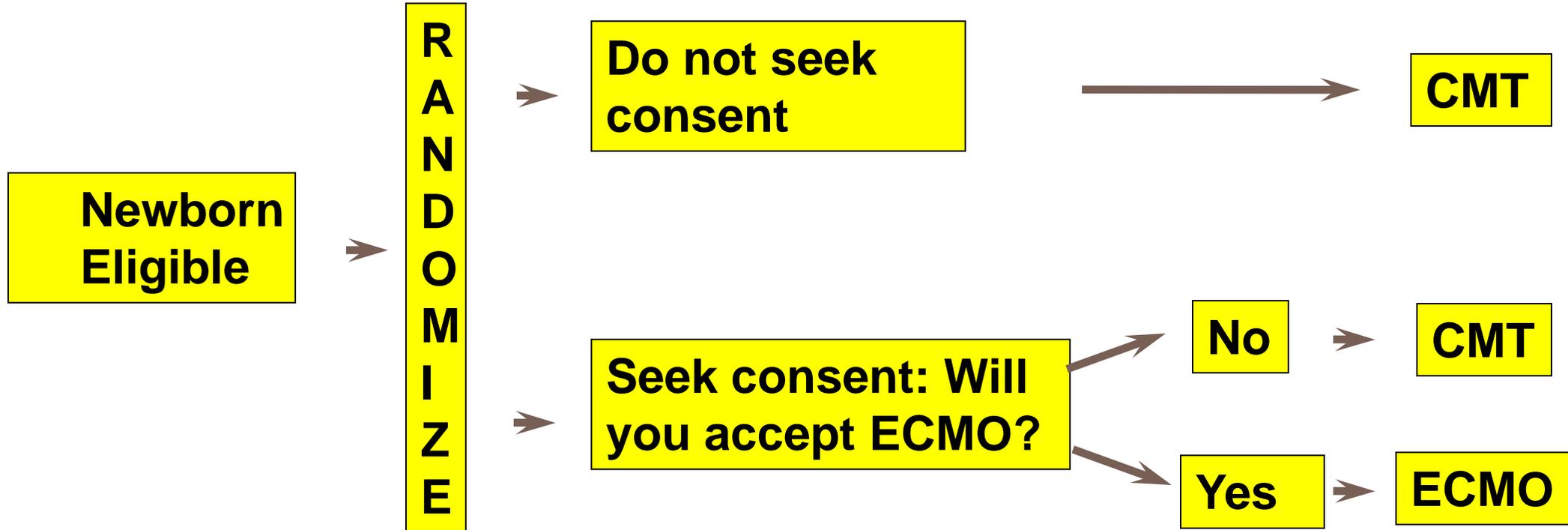
**Harvard School of Public Health**

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# Randomized Consent



# Randomized Consent



# Question

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- Imagine you were on the IRB at Boston Children's Hospital when this study was proposed
- Would you have approved the Zelen randomization scheme?
- Why or why not?

# The ECMO Trial: Justifications for Randomized Consent

- Control patients were not really research subjects
- Parents of control patients were not really being offered a choice, so why subject them to stress?
- Pressure to cross-over from CMT to ECMO would have been unbearable

# The Response to the ECMO Trial

- The NIH Office for Protection from Research Risks (OPRR) reprimanded the hospital
- The hospital IRB “made decisions that rightfully belonged to the parents. They really blew it.”  
Charles McCarthy, Director of OPRR
- The doctors “were doing exactly what physicians did before we had a doctrine of informed consent - making decisions for parents.” George Annas, Boston University



Are RCTs the only way to learn?

# Approaches to Learning: Ascending Order of Confidence

- Meta-analyses
- Randomized Controlled Trials
- Case / Control Observational Studies
- Databases
- Case Series with Historical Controls
- Case Series with Literature Controls
- Case Series without Controls
- Anecdotal Case Reports

# Are RCTs the only way to learn?

- “The brilliant success of the RCT has now become a form of intellectual tyranny” *Freireich*
- “We should not proceed on the fallacious assumption that where there is no randomization, there is no truth.” *Royall*

Special Articles

A COMPARISON OF OBSERVATIONAL STUDIES AND RANDOMIZED,  
CONTROLLED TRIALS

KJELL BENSON, B.A., AND ARTHUR J. HARTZ, M.D., PH.D.

***Conclusions***

We found little evidence that estimates of treatment effects in observational studies reported after 1984 are either consistently larger than or qualitatively different from those obtained in randomized, controlled trials. (N Engl J Med 2000;342:1878-86.)

## Data published in 1988

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- ECMO database of 715 newborns treated with ECMO (no controls)
- These patients had an 81% survival
- ECMO statistically superior to any other treatment with a survival rate less than 78.4%

# Question

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- Given all you've seen, are you now convinced that ECMO is superior to conventional therapy?

# The UK Neonatal ECMO Trial

THE LANCET

## Articles

### **UK collaborative randomised trial of neonatal extracorporeal membrane oxygenation**

- The existing “RCTs of neonatal ECMO... suggested reductions in mortality but were not conclusive.”
- Because they “used adaptive designs, which may have introduced bias...”

**Field et al. UK collaborative randomised trial of neonatal extracorporeal membrane oxygenation. Lancet 1996;348:75-82**

# The UK Neonatal ECMO Trial

- 1993-1995: 185 neonates randomized to ECMO vs CMT
- Trial stopped early by DSMB,
  - ECMO survival 60/93 = 65%
  - CMT survival 38/92 = 41%,  $p < 0.0005$
- Were 22 babies unnecessarily “sacrificed”?

# Conclusions

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- RCTs are usually the best approach for evaluating new therapies, but...
- The conflict between clinician and investigator is profound and can never be entirely eliminated
- Adaptive randomization is one way to balance the competing obligations
- Zelen randomization reduces the psychological burdens of the investigators, but is probably unacceptable

# Conclusions

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“The use of statistics in medical research has been compared to a religion: it has its high priests (statisticians), supplicants (journal editors and researchers), and orthodoxy (for example,  $p < .05$  is “significant” )”

Benjamin Freedman



**“Never, ever, think outside the box”**