Research Involving Adults With Impaired Decision-Making Capacity

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The views expressed in this talk are my own. They do not represent the position or policy of the NIH, DHHS, or US government.

I have no conflicts of interest to disclose.

More information on the topic can be found at: scottkimbioethics.org
Henry Beecher’s 1966 NEJM article describing 22 (notorious) examples of ethical violations...

- 9 of 22 examples involved at least some people who probably had difficulty providing informed consent:
  - Ex 4: “mental defectives and delinquent juveniles” given hepatotoxic drug, biopsies taken, re-challenged with same drug (in one case re-rechallenged!)
  - Ex 6: 18 hospitalized children aged “3.5mo to 18y” in experimental thymectomy
  - Ex 8: 44 pts “second to tenth decade” in age, extreme hypotension induced by drug or maneuvers, with femoral or internal jugular cannulation; confusion induced on purpose.
  - Ex 7 and 9: experiments on unconscious patients
  - Ex 14, 15: study of “impending coma” by giving nitrogenous substances in patients with “chronic alcoholism and advanced cirrhosis”; cannulation of hepatic and renal veins, worsening of confusion, etc.
  - Ex 16: Willowbrook—administration of hepatitis virus to MRDD children
  - Ex 22: 26 normal babies exposed to repeated radiation and urethral catherization.
Commissions, work groups, advisory committees, revision efforts over the years...

- **President’s Commission, 1982**: Making Health Care Decisions: The Ethical And Legal Implications Of Informed Consent In The Patient-practitioner Relationship.
- **Maryland Attorney General's Research Working Group, 1998**.
- **New York Department of Health Advisory Work Group** on Human Subject Research Involving the Protected Classes, 1999.
- **Secretary's Advisory Committee on Human Research Protections (#2!), 2009**: Recommendations from the Subcommittee for the Inclusion of Individuals with Impaired Decision Making in Research
- **NPRM** and final revision of Common Rule 2017
Outline

- Decision-making capacity and impairment

- Are studies with people lacking (or at risk of lacking) decision-making capacity (DMC) permissible?

- If yes, then who should give consent? How should they decide?

- Should there be limits to risks in such research studies? Other protections?

- Brief overview of NIH policy and procedures, as a current example.
Decision-making capacity (DMC) and impairment
Decision-Making Capacity (DMC)

- Part of the informed consent doctrine
  - Decision-Making Competence/Capacity
  - Adequate disclosure
  - Voluntary decision
DMC is function based

- Actual abilities relevant to the decision
- Task specific
- NOT diagnosis ("senile") or label based ("unsound mind").
- Threshold is affected by context, especially risk-benefit.
Definitions

- *Adjudicated capacity/competence*—what a judge determines in a court of law (probate in MI)

- *Capacity/Competence*—a clinician’s approximation of what the courts might say; usually this carries the day.

- *Abilities* relevant to capacity (e.g., Grisso and Appelbaum 1988):
  - Understanding
  - Appreciating
  - Reasoning
  - Communicating a stable choice

- The abilities can be measured reliably and validly by instruments such as MacCAT-CR, etc. but determination of capacity/competence using that data is a judgment call.
Some disorders are risk factors for incapacity

- Cognitive disorders
  - Neurodegenerative—Alzheimer’s Disease, Fronto-Temporal Dementia, etc
  - Neurodevelopmental disorders
  - Injury—strokes, TBI, post-infection, etc
  - Acute confusional states (delirium)
- Psychotic disorders (including mania)
- Mood disorders when severe
- Eating disorders when severe
- Other? Extreme personality disorders? Severe addictions?

NB: risk factor ≠ incapacity!
Prevalence of decisional incapacity: 
**Very rough estimates** (Kim, 2010)

- General hospital inpatients: 30-40%
- Nursing homes: 44-69%
- Psychiatric hospital/units: 30-86%
- Chronic psychoses: ~25-50%
- Mild-moderate depression: Relatively little impact
- Depression, inpatients: 5-24%
- Severely depressed (inc. those with psychosis and cognitive impairment): prob >25%
Impaired decisional capacity is common in Alzheimer’s disease research

- 40% of pts with even Mild Cognitive Impairment (MMSE 27.8±1.8) lack capacity to consent to RCT (Jefferson, JAGS 2008)

- 62-76% of AD patients (MMSE 22-23) in a typical RCT probably lack capacity (Kim, AJP 2001; Warner, JME 2008)

- On the other hand...
CATIE Schizophrenia Study:
Understanding Score Distribution at N=900
(S Stroup)
CATIE Schizophrenia Study: Appreciation Score Distribution
Are studies with people lacking (or at risk of lacking) DMC permissible?
Federal regulations clearly allow it in theory...

- Legally authorized representatives (46.102c)
  - But defers to local and state laws to define LAR
  - Therefore, OHRP guidance turns on state and local laws
  - Revised Common Rule: when no applicable law, institutional policy on surrogate decision-making

- Few jurisdictions have clear policies.
  (e.g., California, New Jersey, Virginia have ‘modern’ laws; some states have other regulations or guidance, e.g., Maryland AG; but most states not clear)
One area of wide agreement: probably the most important ‘advance’ ethically

- Involving those lacking DMC (or at risk) must be specifically justified:
  - Research cannot be done without them.
  - Research focused on disorder causing incapacity.
  - Rarely, OK for other reasons (to avoid discrimination)
“At best, the field is characterized by a patchwork of IRB policies and research practices.”

SACHRP 2009 report’s recommendations, in my opinion, should be the benchmark for IRBs.
- http://www.hhs.gov/ohrp/sachrp%2020090715letterattach.html
Who should give permission/consent, i.e., serve as surrogate decision-maker?

45 CFR 46.102(c): Legally authorized representative [LAR] means an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedure(s) involved in the research.
LAR types: pros and cons

- Legal guardians—appointed by a judge
  - Legal clarity but no necessary link to subject’s values

- Health care proxies (DPOA)
  - Subject’s own choice but must extrapolate to research decision

- De facto family (often legally defined health care surrogate)
  - Reflects reality of most situations; but not as clear as DPOA in terms of subject’s preference of surrogate

- Research proxy
  - Research advance directives—nice idea... but unrealistic
  - Concurrent proxy directives—feasible and important
Guardians can sell the assets and control the lives of senior citizens without their consent—and reap a profit from it.

By Rachel Aviv
SACHRP, 2009: proposed hierarchy

1. As per state or local law, if there is one.
2. DPOA for healthcare
3. Legal guardian
4. Spouse or equivalent
5. Adult child
6. Parent
7. Brother or sister
8. Adult in a special care and concern relationship
Survey of U.S. public (n=1463): **family member as LAR for** dementia research
(Kim et al 2009, *Neurology*)

<table>
<thead>
<tr>
<th></th>
<th>Lumbar Puncture</th>
<th>Drug RCT</th>
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<td>If patients cannot make their own decisions about being in [study scenario], should our society allow their families to make the decision in their place? [% def/prob yes]</td>
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<td>If patients cannot make their own decisions about being in [study scenario], should our society allow their families to make the decision in their place? [% def/prob yes]</td>
<td>72%</td>
<td>83%</td>
<td>71%</td>
<td>68%</td>
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Public attitudes toward family surrogate consent for dementia research: after one day deliberation exercise (n=173) (Kim et al 2011, *Neurology*)

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<td></td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
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<tr>
<td>% probably allow</td>
<td>51</td>
<td>19</td>
<td>56</td>
<td>21</td>
</tr>
<tr>
<td>% definitely allow</td>
<td>33</td>
<td>76</td>
<td>38</td>
<td>76</td>
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Comments during deliberation....

(De Vries et al. Public's Approach to Surrogate Consent for Dementia Research: Cautious Pragmatism. AJGP 2013)

- Participant A: “But if the answer is ‘no,’ that surrogates can’t give consent, then there is no hope for ever getting anywhere. So the answer has to be in my mind, ‘yes.’ “

- Participant B: “By voting ‘nay’ against surrogate empowerment, what you’re essentially doing is voting ‘no’ on every other family. You’re putting yourself in a position of impacting every family who has an Alzheimer’s patient.”
“So it seems as though we almost have no choice but to have some form of surrogate consent, and our challenge is . . . How do we make it work? How do we build protections for, you know, the Alzheimer’s victim . . . the patients . . . “
How much freedom or leeway would you give [your family member] to go against your preference and instead [do opposite of your current preference]?

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<tbody>
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<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
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<tr>
<th>After deliberation (N=168)</th>
<th>No leeway</th>
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<tr>
<td></td>
<td>Some leeway</td>
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How much freedom or **leeway** would you give [your family member] to go **against** your preference and instead [do opposite of your current preference]?

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<th>Drug RCT %</th>
<th>Vaccine %</th>
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<tr>
<td>DD participants after deliberation (N=168)</td>
<td>No leeway</td>
<td>24</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Some leeway</td>
<td>59</td>
<td>57</td>
<td>61</td>
</tr>
<tr>
<td></td>
<td>Complete leeway</td>
<td>17</td>
<td>20</td>
<td>15</td>
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Preserved abilities of incapacitated persons with dementias

- A person who lacks capacity can **voice a “reasonable” preference**. (Kim et al. 2002, *Am J Psych*)

- A person who is incapable of giving informed consent can still do something else, like **appoint a proxy**. (Kim et al. 2011, *Arch Gen Psych*)
Implications?

- Even after diagnosis of Alzheimer’s disease, usually possible to obtain a valid proxy directive.

- As much as possible, involve the patient with dementia in the decision-making process.
Risk-benefit limits?
Most common approach among IRBs (probably)

- Prospect of direct benefit
- No prospect of direct benefit
  - Minimal risk
  - Minor increase over minimal risk
  - Greater than minor increase—IRB cannot approve (in pediatric research, requires special HHS review)
‘...vitally important but ethically acceptable research would be prohibited by adopting “minor increase over minimal risk” as an upper limit of risk.’

“In exceptional circumstances,” research with moderate risk of harm or discomfort OK if:

- Safeguards appropriate to this degree of risk in place
- Research must be of vital importance in the understanding, prevention or alleviation of a serious problem affecting the health or welfare of the study population.
Other protections?

IMPORTANCE OF CONTEXT
Mr. A with Alzheimer’s disease

- Not able to give independent consent
- Retired professor—financially stable, psychosocial resources to seek out clinical trial, spouse and adult children supportive and involved.

- Enrolls in an RCT of a novel intervention
  - Only minor adverse effects seen (1000 people with more advanced AD have received the intervention so far)
  - Goal of slowing down disease

- Strongly desires to be in the study
  - Altruistic motive
  - A desire for benefit—felt to be worthwhile gamble
In contrast…. Mr. S with schizophrenia

- Meets threshold for capacity so can (in theory) consent for self.
- Single, estranged from family, unemployed, socially isolated, racial/ethnic minority.
- RCT of a compound that is already marketed
  - Not a new paradigm
  - Different formulation to optimize effect (e.g., increase adherence)
  - Marketing considerations are probably part of reason for RCT
- No strong incentive to enroll
Other protections and considerations commonly mentioned in various documents

- Well-defined capacity assessment procedures
  - Including: capacity to appoint a proxy
- Respect preserved abilities
  - Assent, Dissent, and collaborative decisions
- Subject advocates
- Study partners
- Consent and study monitors
- Assessment of appropriateness of surrogates
- Other?

NB: should be tailored to context—as contexts do vary a great deal...
NIH Policy and Procedures: (Very) Brief Summary
NIH HRPP SOP 14E
(see also CC policy 87-4)

- Must have prior IRB approval to enroll decisionally impaired persons.
  - Their involvement must be justified
  - Capacity assessment process
  - LAR eligibility and evaluation
  - Risk level and prospect for benefit specified
  - Assent and dissent
  - Any additional safeguards (e.g., monitoring)
Policy varies by risk-benefit category

- Minimal risk (MR)
  - Prospect of direct benefit to subjects
  - No prospect of direct benefit
    - No greater than minor increase over MR, and
      - Not worse off than alternative treatment
    - Greater than minor increase over MR ➔ special review
Special review by panel convened by NIH Deputy Director for Intramural Research; panel must find that the knowledge to be obtained is of:

- vital importance
- cannot reasonably be obtained with those who can consent
- cannot be obtained with less risk
# Risk category by LAR type (NIH SOP 14E)

<table>
<thead>
<tr>
<th>LAR type</th>
<th>DPA or Guardian</th>
<th>Concurrent DPA (only if person currently capable of appointing DPA)</th>
<th>De facto (family) surrogate</th>
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<tbody>
<tr>
<td><strong>Risk-Benefit</strong></td>
<td></td>
<td></td>
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<tr>
<td>MR or Prospect of direct benefit</td>
<td>Allowable</td>
<td>Allowable w concurrently appointed DPA</td>
<td>Allowable (hierarchy per CC or state)</td>
</tr>
<tr>
<td>No prospect DB and minor increase in risk (for higher risk ➔ special panel determines)</td>
<td>Allowable</td>
<td>Allowable w concurrently appointed DPA</td>
<td>Not allowed</td>
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</tbody>
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