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# Committee Says Human Genome Editing Ethically Permissible — Under Certain Conditions

*Ethical framework needed not just for the U.S., but internationally*

Clinical trials on genome editing of the human germline are within the realm of possibility — but only for serious conditions under stringent oversight, concluded a new report from the National Academies of Sciences, Engineering, and Medicine.[1]

"It was no longer realistic to say that it couldn't happen. It isn't possible now, but sometime in the not-so-distant future, it probably will be. Therefore, it's no longer credible to say, 'We're never going to do it,'" says **Richard O. Hynes**, PhD, co-chair of the committee that produced the report.

> "IT WAS NO LONGER REALISTIC TO SAY THAT IT COULDN'T HAPPEN. IT ISN'T POSSIBLE NOW, BUT SOMETIME IN THE NOT-SO-DISTANT FUTURE, IT PROBABLY WILL BE."

Not surprisingly, the question of whether human germline editing should be performed at all was easily the most hotly debated aspect of the committee's work.

"In the past, it's always been assumed that we wouldn't do that — that one couldn't do that. We didn't say it should happen now, but we didn't say it should never happen," says Hynes, a researcher at the Massachusetts Institute of Technology's Koch Institute for Integrative Cancer Research in Cambridge.

Genome editing has already entered clinical trials for non-heritable applications, but should be allowed only



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for treating or preventing diseases or disabilities at this time, says the report. The committee decided on several criteria that should be met before allowing germline editing clinical trials to go forward.

"That was obviously the biggest serious issue," says Hynes. "We spent a lot of time thinking about the pros and the cons, the reasons for doing it, and the reasons for not doing it."

**R. Alta Charo**, JD, Warren P. Knowles professor of law and bioethics at University of Wisconsin Law School in Madison and co-chair of the committee, agrees. "Moving heritable editing of DNA in the nucleus from 'unthinkable' to 'maybe, but only if,' is the clearest break from prior norms," she says.

## Ethical Framework Needed

The following are the two biggest ethical concerns Charo sees currently:

- the risk that some basic science will be hindered by debates surrounding use of gametes and embryos in research;
- that development of somatic therapies and preventive strategies will be complicated by concerns about off-label use for so-called "enhancement."

Hynes says that the ethics of human genome editing, while certainly complex, aren't entirely unique. Stem cell research and in vitro fertilization pose similar ethical questions.

Hynes believes having a set of principles to guide thinking about human genome editing is very important, "not just for the U.S., but internationally," as a framework for countries with widely varying views on the practice to consider.

Hynes notes, "Some countries really think the procreation of genetically engineered children is a crucial thing to do." Other countries take a completely contradictory view: that scientists shouldn't interfere with natural processes.

"It has to be thought about internationally," says Hynes. "We have to deal with the fact that the cultures are different."

Additionally, some countries are poorly regulated. "We can't tell another country how to run their show," says Hynes. "But we can think about how to influence how they do it."

The committee spent a good deal of time discussing the ethical implications of human enhancement. "The term 'designer babies' is often used, but means different things to different people," says Hynes. "That's

## EXECUTIVE SUMMARY

Stringent oversight might be necessary in order for heritable germline editing clinical trials to be conducted, according to a new report indicating use of the technique could be ethically permissible, but only for treating or preventing serious diseases.

- Moving heritable editing of DNA in the nucleus to the realm of possibility is the clearest break from prior norms.
- There is a need for encouragement of public engagement.
- The issue of human enhancement will likely be revisited as technology improves.

controversial, and it should be. People should think about that very hard, although the more extreme scenarios, such as producing children with higher intelligence, are completely unrealistic at this time."

Somatic gene editing holds promise for treating patients with a genetically inherited disease — such as sickle cell disease — by editing cells from that person and putting them back — not heritably, but just for that individual patient.

"Somatic gene editing is becoming more and more possible. New genome editing technologies are more accurate, cheaper, and easier to do," says Hynes. "So that's going to accelerate. Some applications are already in clinical trials, and there will be many more."

Virtually everyone agrees that treating or preventing disease is a good thing. With a muscular dystrophy patient, for instance, the patient's muscles could be improved using this approach. "People are working on it and it will happen," says Hynes.

Successful use of the technique to treat diseases opens the door to the possibility of human enhancement. Similar techniques could be used to make muscles stronger in a healthy person, for instance.

"That has all sorts of societal implications that we need to think about. And we said, 'Not now,'" says Hynes. "It's not so clear that there are benefits to making somebody stronger than they were." Therefore, the risk/benefit ratio would not allow enhancement to be approved by the FDA — at least not at this point.

"That could change over time. The risks will fall, and will be understood better," says Hynes. In the near future, people may want to use gene editing to improve themselves. For instance, it could be possible to increase resistance to infectious diseases. "It's a very difficult line to draw. Where do you say it's OK — and where do you say it goes too far?" asks Hynes.

Gene therapy has been performed for some time, adds Hynes, "but not very effectively, because the technology wasn't very good. It's much better now, and it will work, for sure, for some things." When the science improves, issues like enhancement will certainly come up, but the committee was clear that human enhancement should not happen.

Hynes acknowledges that this is a moving target. "Decades down the road, it will probably have to be looked at again," he says.

Some ethical issues involving gene editing can be addressed with regulatory guidance. Others, like the issue of some people making themselves stronger and others unable to afford it, are broader in scope. "These are societal issues, as much as technical ones," says Hynes.

Seventy-three percent of Americans predict gene editing will become available before it has been fully tested and understood, found a recent Pew Research survey.[2] Opinions were closely divided on whether such techniques are "meddling with nature," or no different from other ways that humans have tried to better themselves. Regarding human enhancement, 73% of respondents believe inequality will increase if brain chip implants become available, because initially they will be obtainable only by the wealthy. Most respondents felt that the downsides would outweigh the benefits for society.

"The public is diverse and comes to these things with multiple points of view," says Hynes, adding that there is a need to foster public engagement and promote discussion. In the United Kingdom, the issue of whether to allow mitochondrial replacement therapy, a type of assisted reproduction that could allow some families to avoid passing on genetic disease, was debated in 2016. "There was a serious effort made to inform the public, then listen to what they had to say," notes Hynes. The British government asked the public to share their thoughts; the eventual decision was made to allow the procedure. "The public basically said, 'If kids are going to have a dreadful disease, why not fix it?" says Hynes.

The public can contribute points of view on human genome editing that a group of scientists and ethicists might not necessarily have thought about. "I think we all agree that's something that should be part of the way we think about these things going forward," says Hynes. ■

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# Study: Scientifically Unproven Marketing Claims Very Common on Websites

*Some advertised interventions are potentially harmful*

A significant percentage of the public seeks health advice from complementary and alternative medicine (CAM) practitioners. "People may be relying on this information to make important treatment decisions," says **Timothy Caulfield**, LLM, FRSC, FCAHS, one of the study's authors and research director at University of Alberta's Health Law Institute in Canada.

Much of this advice relates to allergies and asthma. "We thought it important to get a sense about what is being offered," says Caulfield. Researchers analyzed marketing claims made on 392 websites by Canadian chiropractors, naturopaths, homeopaths, and acupuncturists relating to the diagnosis and treatment of allergy and asthma.[1]

Naturopath clinic websites have the highest rates of advertising at least one diagnosis, treatment, or efficacy for allergy or sensitivity (85%) and asthma (64%), followed by acupuncturists (68% and 53%, respectively), homeopaths (60% and 54%), and chiropractors (33% and 38%).

Of the interventions advertised, few are scientifically supported. The majority lack evidence of efficacy, and some are potentially harmful, found the researchers.

"While we knew that CAM providers were working in the areas of allergy and asthma, we were surprised how common it was to mention treatments," says Caulfield.

Eighty-five percent of naturopaths, for example, advertised a diagnostic procedure or treatment, or commented on the efficacy of these approaches. "Given the lack of evidence to support these practices, this is a worrisome trend," says Caulfield.

Caulfield believes regulators should monitor the use of misleading health claims. "These claims appeared on the websites of individuals and clinics holding themselves out as healthcare professionals," he says. "I think we can all agree that the public should have access to reliable health information."

Clinicians have the same informed consent obligations whether they are providing conventional or CAM therapies, says **Michael H. Cohen**, JD, a Silicon Valley, CA-based attorney specializing in healthcare legal and regulatory issues, especially involving CAM and integrative medicine. Cohen is a former assistant professor of medicine at Harvard Medical School.

This means discussing the potential risks, benefits, and alternatives of a given therapy. Many therapies carry some risk of harm, whether conventional or CAM. "This does not mean they are inherently unethical," says Cohen. "It does mean that providers must take the time to have clear discussions with patients, and document that these conversations have occurred."

Failure to provide adequate informed consent generally is considered unethical, adds Cohen, and can be grounds for a malpractice action. Additionally, when physicians create their own line of products, going beyond clinical recommendations to their patients, such physicians can face enforcement actions from the FDA and the Federal Trade Commission (FTC). While the FDA generally does not intrude on the practice of medicine, says Cohen, "it does have jurisdiction over products in interstate commerce, and this is interpreted broadly."

FDA and FTC require that manufacturers and distributors of healthcare products substantiate their claims through "competent and reliable scientific evidence," explains Cohen.

"Beneficence includes

## EXECUTIVE SUMMARY

Marketing claims on websites of complementary and alternative medicine (CAM) therapies practitioners regarding allergy and asthma often included interventions that were not scientifically supported. Some ethical concerns:

- Most of the advertised treatments lacked evidence of efficacy.
- People may be making important treatment decisions based on unreliable information.
- Clinicians have the same informed consent obligations whether they are providing conventional or CAM therapies.

recommending therapies of potential benefit whether they are in the conventional or 'CAM' domain," Cohen adds. The physician has an ethical duty not only to do no harm, but also to actively promote the patient's well-being. "The best way to do this is through an open mind that reviews the literature, listens compassionately and sensitively to the patient, and takes into account the panoply of therapeutic options, with the patient actively engaged in decision-making," says Cohen.

## Intent Is Relevant

**Geraldine M. Jacobson**, MD, MPH, MBA, chair and professor in the department of radiation oncology at West Virginia University School of Medicine in Morgantown, points out that chiropractors, naturopaths, homeopaths, and acupuncturists all are represented by professional associations which have codes of ethics.

"Common themes in these codes of ethics are to focus on the care of the patient and not to take advantage of the patient for personal or financial gain," says Jacobson.

When a health practitioner recommends a treatment, the principle of autonomy, which includes informed choice of treatment, dictates that the practitioner should be honest about the potential benefits and harms, says Jacobson.

"If the practitioner is aware that there is no scientific basis to the recommended treatment, that information should be shared with the patient," she says. Jacobson says the following are unethical practices:

- if the practitioner promotes a treatment solely for financial gain without the expectation of benefit to the patient;
- if a practitioner is promoting a treatment that he or she knows is potentially harmful, and does not share this information with the patient.

When recommending treatments that are not scientifically supported, the practitioner's intent matters, says Jacobson. If the practitioner has experience with a treatment, has found it beneficial, and has not been informed of harmful effects, it may be ethical to recommend the treatment, if the intention is to benefit the patient.

"Not all alternative forms of treatment have been scientifically tested," notes Jacobson. For example, acupuncture has now been shown to be effective for multiple conditions, but has been practiced for centuries without being subject to scientific investigation. Jacobson says this approach is best: "In a situation where there is lack of supporting data for a treatment, but practical experience suggests benefit, this information should be truthfully shared with the patient." ■

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# Updated Common Rule: 'Massive Improvement' For Human Subjects Research

*Informed consent requirements streamlined*

The long-awaited updated Common Rule for federal regulations for ethical conduct of human subjects research is quite different from what was initially proposed.

The updated rule is a "massive improvement over the 1990s version that had essentially become antiquated the moment it hit the presses," says **James G. Hodge, Jr.**, JD, LLM, professor of public health law and ethics at the Sandra Day O'Connor College of Law at Arizona State University in Phoenix.[1]

A number of controversial changes

that were originally proposed did not make it into the final version. "After reviewing more than 2,100 comments on changes we proposed in our earlier Notice of Proposed Rulemaking, we made a number of significant changes in our final rule," says **Jerry Menikoff**, MD, director of the U.S. Department of Health and Human Services (HHS) Office for Human Research Protections, which led the government's efforts to overhaul the regulations.

The final rule does not require that research involving non-identified biospecimens be subject to the Common Rule, and it does not require that consent be obtained in order to conduct such research. In general, researchers can continue to use such biospecimens in the way they are currently using them.

In Hodge's estimation, "The research enterprise in the U.S. just got more streamlined without sacrificing privacy or protection."[2] The following are some changes:

**• Informed consent forms will be changed to facilitate research participants' understanding of the study's scope, including its risks, benefits, and alternatives to participating in the study.**

"Over the years, many have argued that consent forms have become these incredibly lengthy and complex documents that are designed to protect institutions from lawsuits, rather than providing potential research subjects with the information they need in order to make an informed choice about whether to participate in a research study," said Menikoff.

The final rule will now generally expect consent forms to include a concise explanation at the beginning of the document of the key information that would be most important to individuals contemplating participation in a particular study. This should include purpose of the research, the risks and benefits, and appropriate alternative treatments that might be beneficial to the prospective subject.

"We are very hopeful that a new emphasis on concise and focused information will do a much better job explaining research studies to potential participants than 25 pages of charts and boilerplate," says Menikoff.

**• The updated rule clarifies what constitutes research for the purposes of IRB oversight.**

While the definition of research is unchanged, "what's clearly classified now as non-research is important," says Hodge. "It represents seminal changes."

Public health surveillance activities are not classified as research. This has been much debated, especially in hospital settings. "Hospital CEOs and others question whether they can share data for surveillance purposes, because they view surveillance mistakenly as research," says Hodge. "The Common Rule clarifies that it's not research."

**• The updated rule lessens the burden for studies with very minimal risks, such as studies involving access to private data, or access to biospecimens that are not linked to specific persons.**

"We are expecting a lot less IRB oversight of ongoing, longitudinal studies," says Hodge.

Certain types of educational studies, such as health oversight activities and minimal risk psychological examinations, that might have somehow garnered a research classification in the past are generally not to be considered research going forward.

Some advocated for the Common Rule to apply to all research activities across the board in all settings — whether funded by local, state, or federal governments, or even the private sector. "That was not adopted, but could have changed the game for some private-sector hospitals," notes Hodge. "Any attempt to apply Common Rule protections beyond federally conducted or funded research is the choice of the hospital."

A commonly debated question is: How concerned should Americans be about unwarranted, undocumented use of their data for tissue samples? In Hodge's view, "The truth is, not very. This is the type of activity that will advance medical causes or public health-related findings with little to no risk to the subjects themselves."

Detecting longitudinal patterns with potential public health implications is the type of work that "opens the door to better outcomes, and it can be revisited if privacy breaches or other abuses arise," says Hodge.

## EXECUTIVE SUMMARY

The updated Common Rule for ethical conduct of human subjects research is significantly different from what was initially proposed. Some changes include the following:

- Researchers do not need to obtain direct consent from persons involved in certain minimal-risk studies involving biospecimens.
- Public health surveillance activities are not considered research.
- Researchers can obtain broad consent to reuse participant biospecimens or other data in secondary studies.

**• If a participant is involved in a federally funded minimal-risk study involving biospecimens or private data, clinical researchers will not have to seek direct consent.**

"This is a substantial change that was contentious," says Hodge.

Some wanted consent for any type of study whatsoever involving secondary research. Others wanted no consent for any studies that involved only biospecimens.

"That debate was solved in this new revised rule with an appropriate balance," says Hodge.

After obtaining consent for advance use of biospecimens and other data from a research subject, researchers will not have to revisit consent for every future secondary use of that particular data.

"That is a huge plus for the research community," says Hodge. "It allows all kinds of research that previously would not have been conducted or may have been shut down." This is because of the expense of having to either revisit informed consent or obtain a waiver from an institutional review board.

None of this means that research can be performed on individuals in clinical settings without informed consent. "That is not what the rule is about. It's about tissue samples and private identifiable information," says Hodge. "How clinical research is conducted in the U.S. largely remains the same."

## Revisited as Needed

Hodge points out that the updated Common Rule is not written in stone. "One of the great things is that some key provisions of the rule can be revisited and revised, allowing for a more flexible rule in the years ahead," he says.

What constitutes a biospecimen in the current version could be adapted to keep pace with technology and societal conceptions, for instance. The ability to deduce an individual's identify from databases or biospecimens might also need to be revisited.

"Four years from now, we can make changes to the Common Rule to reflect the latest technology," says Hodge. ■

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# NIH Policy On Review Of Multicenter Studies: 'One Size Fits All'

A new National Institutes of Health (NIH) policy mandates that all domestic sites participating in multicenter research studies use a single institutional review board (IRB).[1] **Eric Juengst**, PhD, director of the University of North Carolina (UNC) Center for Bioethics in Chapel Hill, has some ethical concerns about this requirement.

"The main ethical concern that challenges all efforts at centralized review for multicenter studies is the loss of local perspectives on the issues involved in recruiting, informing, and respecting human research participants," he explains.

Different sites draw from populations in different socioeconomic and environmental conditions, and with different relationships between the community and the biomedical research enterprise.

"The de-centralized approach, for all its inefficiency, allowed reviewers with local knowledge to take these differences into account," says Juengst. This ensured "precision protection" for research participants, he adds, just as "precision medicine" aspires to use individualized data to tailor clinical interventions.

Another ethical concern: When the centralized review is undertaken by for-profit IRBs, the profit motive inevitably introduces risks of bias and conflict of interest. "It is a little ironic that NIH is advocating a one-size-fits-all approach to protecting human participants in research, just as that research is turning increasingly to the search of precision approaches that are dedicated to individualizing factors in healthcare," says Juengst.

The rationale for the new NIH policy prescribing the use of single IRBs for multicenter trials is the

need to increase the speed and efficiency of the research review process. The aim is to expedite research that might benefit patients and the public, says Juengst. However, he says, this comes at the expense of just the sort of "precision ethics" that the localized IRB system was designed to facilitate.

"This puts the research imperative in direct tension with the commitment to earning public trust that has enabled biomedical research to flourish as it has in the last decades," Juengst concludes. ■

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# Research Misconduct Rarely Reported By Authors of Systematic Reviews

Research misconduct — not publishing completed research, duplicate publications, or selective reporting of outcomes — sometimes is identified by authors of systematic reviews, but is rarely reported, found a recent study.[1]

Researchers analyzed 118 systematic reviews published in 2013. Some key findings include the following:

• Unpublished trials were searched in 66% of reviews.

• Authors of original studies were contacted in 62% of reviews.

• Duplicate publications were searched in 69% of reviews.

• Only five reviews looked at conflicts of interest of study authors. None of them analyzed the effect.

• Seven reviews suspected misconduct, but only two reported it explicitly.

Guidance on when, and how, to report suspected misconduct is needed, the researchers argue.

"Depending on the nature of the misconduct, when the scientific record goes uncorrected, people may rely on invalid 'evidence' to support practice, policy, or their approach to a problem," says **Karen Christianson**, RN, BSN, CCRP, associate vice president at HRP Consulting Group in Lake Success, NY.

This is particularly troubling in healthcare, says Christianson. This is because physicians and other providers may base their approach to treatment on false evidence. In turn, this may result in unanticipated adverse effects, outcomes, or other negative consequences. "Now imagine the impact of this over time, across hundreds or thousands of lives," says Christianson.

> "MOST SCIENTIFIC ORGANIZATIONS AND RESPECTED JOURNALS HAVE ESTABLISHED POLICIES AND PROCESSES TO ENSURE THAT SUCH CONCERNS ARE EVALUATED."

Christianson believes there is an ethical obligation to report suspected misconduct — if not to the organization who employs the scientist, then to the journal which published the work in question. "Most scientific organizations and respected journals have established policies and processes to ensure that such concerns are evaluated and, if warranted, investigated," she notes.

Most have established mechanisms for anonymous or confidential reporting, and non-retaliation policies. If misconduct did occur, the work in question is likely to be retracted. "This then sets the path for other scientists to perform research which may validate or refute the prior findings, correcting the scientific record," says Christianson. ■

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# It's Not Just MDs: Patient Advocacy Organizations Have Industry Ties, Too

*Growing focus on groups' funding*

Physicians' financial ties to industry are well-known and now publicly available — but less attention is paid to industry funding of patient advocacy organizations. Two recent studies examined these ties, with similar findings.

One study revealed that more than 80% of 104 large patient advocacy organizations receive financial support from drug, device, and biotechnology companies. Additionally, industry executives often serve on governing boards.[1]

"Going into the study, we knew that some patient advocacy organizations received support from drug and device companies. But we were surprised at how ubiquitous these sorts of relationships were," says **Matthew McCoy**, PhD, the study's lead author and a postdoctoral fellow at the University of Pennsylvania's Perelman School of Medicine.

The researchers also were struck by the limited transparency around this funding. Most organizations provided a list of their donors, but only 57% also included the amounts of individual donations. Most of those disclosed donation amounts using broad ranges, such as "between $100,000 and $200,000," instead of exact figures. Very few organizations indicated how donations were used.

"From the perspective of someone trying to assess the severity of a patient advocacy organization's financial conflicts of interest, the information that's out there is, in most cases, insufficient," McCoy says.

## Most 'Full of Integrity'

Another group of researchers surveyed 289 patient advocacy organizations about financial relationships with industry, with 67% reporting receiving industry funding. Nineteen received more than half of their funding from industry.[2]

Twenty-two patient advocacy organization leaders perceived pressure to conform their positions to the interests of corporate donors. **Susannah Rose**, PhD, the study's lead author and scientific director of research at the Cleveland Clinic's Office of Patient Experience, reports, "A much larger percentage of patient advocacy organizations receive money from for-profit industry than we anticipated."

The researchers also examined the perceived effectiveness of conflict of interest policies. Not many leaders saw theirs as particularly effective. "Leaders thought they could be strengthened," says Rose. "Many are interested in this issue. They really want help in dealing with conflicts of interests."

However, many lack the necessary resources and knowledge to effectively address this. Some groups have only a handful of staff members. "Most of the organizations are full of integrity. They want to do the right thing," says Rose, who authored a recent paper on how to improve conflict of interest policies at academic medical centers.[3] She offers the following ways in which patient advocacy groups can tackle the issue:

**• Groups can simply stop taking money from industry.**

This is a realistic possibility for organizations that take relatively low amounts of money from industry. "Some take a lot, but there is a good number that aren't fully reliant on industry," notes Rose.

**• Groups can be more transparent about the funding they receive.**

Both studies showed that information on industry funding is not usually readily available on the group's websites.

As a psychotherapist at Memorial Sloan Kettering, Rose routinely referred her patients to advocacy organizations. Many provided counseling services and gave advice on various treatment options and drugs. "I was shocked, to be honest, to find out that many are highly


## EXECUTIVE SUMMARY

Recent studies have revealed surprising financial ties of patient advocacy organizations: the vast majority receive financial support from drug, device, and biotechnology companies. Some ethical concerns include the following:

- Very few organizations indicated how donations were used.
- Some leaders felt pressured to conform their positions to the interests of corporate donors.
- Groups lack resources to improve conflict of interest policies.

funded by the pharmaceutical companies," she recalls. While that wouldn't necessarily have discouraged Rose from making referrals to the groups, she found it disconcerting that the information wasn't more readily available.

In McCoy's view, to the extent that patient advocacy organizations do have financial conflicts of interest, they ought to be as transparent as possible about it. "Knowing how severe they are and how they're managed allows their constituents and the broader public to draw their own conclusions about the credibility of the organization," he explains.

The Physician Payments Sunshine Act requires drug and device companies to report payments to doctors. These payments are readily searchable in the Centers for Medicare & Medicaid Services' Open Payments database. No such requirement exists for patient advocacy groups.

The researchers argue that the requirement for mandatory reporting should be extended to cover industry payments to patient advocacy groups. "We aren't the first ones to make this suggestion," says McCoy. The Institute of Medicine (IOM) recommended this in a 2009 report.[4] However, that recommendation was not incorporated into the Affordable Care Act.

"Given our research, and the work of others which now shows how ubiquitous industry support of patient advocacy organizations is, we think it's time to revisit the IOM's recommendation," says McCoy.

## Undue Influence Possible

McCoy is concerned that industry funding could influence patient advocacy organizations to act in ways that advance the interests of industry funders, but aren't aligned with the interests of their constituents.

"This isn't to say that accepting industry funding necessarily leads to undue influence. But it's a risk factor for such influence," says McCoy. The groups are claiming to act on behalf of a particular patient population. Thus, says McCoy, "it's incumbent upon that organization to minimize threats to the integrity of its mission."

Rose sees advocacy groups as unique and distinct in some ways. "Professional organizations, hospitals, and doctors usually have a very important, but narrower, role to play," she explains. "You don't see them having their hands in all aspects of health."

Not only do advocacy groups have direct access to patients, but their influence also reaches all the way up to Congress and the FDA. "The groups are usually very trusted, and try very hard to advocate for the population they represent," says Rose. "But they fall under the radar in terms of their relation with industry."

Industry funding is not necessarily a bad thing, says Rose — in fact, it can be crucial to support the mission of advocacy groups. "On the other hand, they don't want to be beholden to funders' interests," she says. "This is a classic ethical issue for organizations to grapple with." ■

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### SOURCES


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# Study Sheds Light On Surrogates' Decision-making

It comes as no surprise to anyone with experience caring for patients at the end of life that family members often have difficulty predicting a patient's desire for life-sustaining treatments. Reasons for this are less well-understood, however.

"Past efforts to identify factors associated with inaccuracy in

predicting desire for treatment have been rather disappointing so far," says **Gina Bravo**, PhD, a professor of public health at Canada's University of Sherbrooke.

Researchers hypothesized that the reason family members have difficulty in predicting a loved one's desire to receive treatments in hypothetical situations is because of discrepant quality of life assessments.[1]

"My hypothesis was based on intuition, rather than previous studies. To my knowledge, no studies had yet explored this issue," says Bravo, the study's lead author. Previous research had inconsistent findings. "One study would find women, for example, to have better predictive abilities than men, another would find men to be more accurate, while a third would conclude that both genders were equally accurate," says Bravo.

Intuitively, one would expect surrogates who live with the older adult to have better predictive abilities. "Cohabiting provides more occasions to discuss the type of healthcare a person would want, should he or she become decisionally incapacitated," notes Bravo. "Yet, here again, results are mixed."

In fact, most studies conclude that cohabiting does not make a person better in predicting whether a close relative would want to receive a given treatment. "This is a somewhat counterintuitive result," says Bravo.

## New Interventions Needed

Bravo believed that inaccuracy in predicting desire for treatment could be due to inaccuracy in judging quality of life. The researchers asked 235 community-dwelling adults aged 70 and over to rate their quality of life and desire for specified interventions in their current state, mild to moderate stroke, incurable brain cancer, and severe dementia.

A surrogate chosen by the older adult was asked to predict the older adult's responses. The more the surrogate overestimated quality of life compared to the older adult, the more he or she overestimated the older adult's desire to be treated.

The finding underscores the importance of discussing anticipated quality of life in states of cognitive decline, the researchers wrote.

Bravo sees the fact that surrogates typically rate quality of life more poorly than their close relatives as an important ethical consideration. "This phenomenon has been observed in many different populations," she says.

Having rated quality of life poorly, the surrogate would then be inclined to refuse an intervention proposed to their relative — perhaps unknowingly going against their relative's wish. "This could have serious consequences for the relative, especially if the proposed intervention was life-prolonging," says Bravo.

The study's findings suggest that greater understanding on the part of the surrogates could help them make decisions more in line with those that their relatives would have made for themselves. "What we found, however, is an association — not a causal relationship," notes Bravo. "Hence, the next step would be to formally test, ideally in a randomized trial, new interventions to determine whether they help surrogates to make more consistent decisions."

Bravo says future developments in this area are not easy to predict. "There is a need, though, to design new interventions aimed at helping potential surrogates better understand how their older relatives view life under hypothetical states of severe cognitive impairment," she says. ■

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### SOURCE


- **Gina Bravo**, PhD, Professor of Public Health, University of Sherbrooke, Canada. Email: Gina.Bravo@USherbrooke.ca.


## CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Discuss new developments in regulation and health care system approaches to bioethical issues applicable to specific health care systems;
2. Explain the implications for new developments in bioethics as it relates to all aspects of patient care and health care delivery in institutional settings;
3. Discuss the effect of bioethics on patients, their families, physicians, and society.

## COMING IN FUTURE MONTHS

- Ethical issues if hospitals are accused of "price gouging"
- Obtaining consent for research from families of ICU patients
- Why integrity of scientific research is being scrutinized
- Obstacles to providing palliative care to pediatric patients

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# CME/CE QUESTIONS

1. **What did a committee conclude regarding human genome editing, according to a report from the National Academies of Sciences, Engineering, and Medicine?**

   a. Genome editing should be allowed only for treating or preventing diseases or disabilities at this time.
   b. Current oversight is overly stringent and could have a chilling effect on scientific discoveries.
   c. It is unethical for human germline editing to proceed at this time, because of mounting evidence that the risks outweigh any potential benefits.
   d. There is no difference, ethically speaking, between genome editing used for disease treatment and genome editing used for human enhancement.

2. **Which is true regarding marketing claims on websites of complementary and alternative therapies practitioners regarding allergy and asthma, according to Michael H. Cohen, JD?**

   a. None of the advertised interventions were potentially harmful in any way, alleviating most legal and ethical concerns.
   b. The ethical principle of beneficence includes recommending therapies of potential benefit, regardless of whether these are conventional or alternative.
   c. There is a higher standard for informed consent for complementary and alternative therapies because of a greater risk of harm.
   d. The majority of state regulations ban advertisement of any treatments which are not scientifically proven, with widespread monitoring in place.

3. **Which is true regarding the updated Common Rule for human subjects research?**

   a. Far more stringent IRB oversight of ongoing, longitudinal studies can be expected.
   b. Researchers now must obtain direct consent from participants in minimal risk studies involving biospecimens.
   c. Public health surveillance activities now are formally classified as research.
   d. Researchers can obtain broad consent to reuse biospecimens in secondary studies without having to re-obtain consent for each future study.

4. **Which is true regarding a report on research misconduct, according to Karen Christianson?**

   a. Authors of systematic reviews have no ethical obligation to report misconduct.
   b. There is an ethical obligation to report suspected misconduct to the journal that published the work in question.
   c. Reporting can do more harm than good, since most scientific organizations lack established policies to ensure valid concerns are investigated.
   d. Mechanisms for anonymous or confidential reporting are uncommon because they are considered to be unethical.