

The meeting of psychiatry and humanities: an overview

Shahin Akhondzadeh^{1*}, Seyed Hesameddin Abbasi²

1. Psychiatry Research Center, Roozbeh Hospital, Tehran University of Medical Sciences, Tehran, Iran.

2. Central Hospital, National Oil Company, Tehran, Iran.

*Corresponding author: Shahin Akhondzadeh

Address: South Kargar Street, Tehran 13337, Iran.

Tel: (+98) 21 88 28 18 66

Fax: (+98) 21 55 41 91 13

E-mail: s.akhond@neda.net

Received: 20 May 2009

Accepted: 29 May 2009

Published: 30 May 2009

J Med Ethics Hist Med. 2009; 2:5.

© 2009 Shahin Akhondzadeh and Seyed Hesameddin Abbasi; licensee Tehran Univ. Med. Sci.

Abstract

Concerns regarding ethics of psychiatric research were a critical point in research when lots of news was announced about human rights abuses in the Nazi Germany. However, even nowadays, psychiatric research involving people suffering from different types of psychiatric disorders can still be distorted and, rather than fulfilling its promise of improved understanding of psychiatric disorder and its treatment, can result in serious harm to patients who participated in these investigations. This review focuses on some important ethical aspects in psychiatric research.

Keywords: Psychiatry, Ethics in psychiatric research, Humanity.

Respect for persons

Medical Sciences is for the benefit of human, and one of the first strictures of medicine in general and psychiatry in particular is to do no harm. The psychiatrist-researcher has difficult task of fulfilling both the role of psychiatrist and of researcher, in that order. Generally, the first two considerations in studies involving human subjects are "Do the ultimate benefits of the research outweigh the risk for those taking the risks?" and "Is the potential benefit to mankind sufficient to ask someone to take risks for the benefit of others?" Answering either requires some assessment of risks and gains, the risk/benefit ratio. Obviously, the goal is to minimize risk and maximize gain (1, 2). A potentially dangerous

therapy, for example may be justified to save a life but not to ameliorate a simple anxiety (3). The three basic principles set forth in the Belmont Report are as follows:

1. Respect for persons: A person is entitled to choice, dignity, privacy, and confidentiality. Respects for persons incorporate at least two basic ethical convictions: first, that individual should be treated as autonomous agents and second, that persons with diminished autonomy and thus need of protection are entitled to such protection (3).
2. Beneficence: Maximize good/minimize harm. On a practical basis this means that the research effort is to be constructed so as to maximize the anticipated benefit to the subject while minimizing any foreseeable risk. Two general

rules have been formulated as complementary expression of beneficent in this sense: A) do no harm, B) maximize possible benefits and minimize possible harms (4-6).

3. Justice: Justice requires that we treat persons fairly and give each person what she or he is due or owed. The philosophical underpinnings of the concept of justice are complicated and beyond the scope of this text, but in a practical matter come down to the following: A) there will be no exploitative or coercive recruitment of subjects, and B) those bearing risk of a condition will have a right to participate in and reap benefits of research (1-3, 7).

Informed consent

Generating a good consent form is probably one of the most important aspects of one interaction with institutional review board (IRB); not providing one is likely to result in delays in the approval process in the form of stipulations. Two issues need special consideration in relation to psychiatric research involving people suffering from mental illness (8). Firstly, possible inability of the potential research participant to make rational and considered decisions and, secondly, the protection of people subject to legislated involuntary treatment (9, 10).

A standard consent form requires the investigator to:

- A. Identify the study as a research study and describe the object and procedures of the study in non technical, easily understood language.
- B. State that participation is voluntary and can be terminated by the subject at any time without prejudice to subsequent care.
- C. Explain how subjects are selected.
- D. List of the foreseeable benefit and risks of the study to the subjects.
- E. Ensure confidentiality.
- F. List alternative therapies
- G. Explain treatment plans for any untoward effects (11-15).

The use of a guardian or proxy is controversial because of significant pitfalls. Whereas, a proxy's consent might be necessary if a patient is to receive a medical treatment, whether there is an expected benefit with a medically acknowledgement risk, different factors are opening in entering a research study, where one must assume a certain risk for altruistic reasons; this must be a personal choice (12, 13, 16, 17).

Subject selection and recruitment

Subject selection can be even trickier than assessing the risk/benefit ratio. Everyone agrees that subjects in human research should be free, uncovered volunteers, fully aware of the study and

its risk. Sometimes this is much easier to say than to do (14, 15). Informing mentally intact medical subjects is largely a matter of defining unfamiliar terms. The task is much more difficult when dealing with individuals with mental illness, and is especially difficult when dealing with children who are mentally ill or retarded. On the other hand, without study, no treatment can ever be devised. Clearly, that is evil. Imposing a treatment on one individual based upon the consent of another, be illegal guardian or parent, may also be evil. Indeed, there really is no general solution to the dilemma. Each case is unique and must be assessed separately (15). Accordingly, institutional review boards were separated from the investigator. It is difficult task to review assessments of risk/benefit ratios, assure subject anonymity, and assess inclusion and exclusion criteria, recruiting procedures, and adequacy of informed consent. They must also ensure that coercion of any kind, economic, or social, is absent, that provisions are made for subjects to withdraw from the study at will and without prejudice, and that subjects receive medical treatment for any untoward effects (13, 14).

Drug-free Studies, washout studies, and placebo research

Beyond institutionally mandated ethical principles are ethical problems within experimental protocols. A typical example is whether drug tests should compare a new drug against placebo; against another, therapeutically accepted drug; or against nothing. The first alternative controls for the psychological (and thereby physiological) effects of the new drugs, are using placebo. The second (and most favored by review board) treats both groups but assumes that the comparison drug, at the given dose, is active against the population tested. The third determines if the drug alters the natural course of the disease (17). Each of these approaches poses a moral dilemma. In drug-Placebo studies, the advantage of determining if the drug is better than nothing is offset by leaving one group essentially untreated (but also spared side effects). The drug-drug comparison has the advantage that both groups are treated but the disadvantage is that neither treatment, for that group, may be better than no treatment. The last has advantage of assessing the drug against the natural course of the disease but again at cost of leaving one group untreated (18, 19).

In May 1994 the Office for the Prevention of Research Risks (OPRR) of the NIH reported two complaints against schizophrenia researchers at the University of California-Los Angeles (UCLA). This important study involved a group of patients with schizophrenia who were followed on a fixed dose of Prolixin Decanoate (a typical

antipsychotic) for 1 year and then, after a withdrawal protocol, randomized to Prolixin versus placebo for up to 1 year, or until psychotic relapse occurred. The study was looking into predictors of successful functioning exclusive of neuroleptic medication. The OPRP found that the monitoring of patients was acceptable. However, faults were found with the informed-consent process and with the clinicians' not being clear that they were also acting as investigators. Indeed, one of the research subjects was quoted as saying he was delighted to get into the research program "because I thought I was going to get the premier treatment, while they did a little research on the side". During this period, one subject experienced a severe relapse and threatened to kill his parents, at one point approaching his mother with a carving knife. One year after leaving the study, a former subject who was drug free but was still being studied by the researchers committed suicide (17-19).

There are significant potential ethical pitfalls to be considered in the use of placebo controlled groups, particularly in psychiatric populations. Indeed, the Declaration of Helsinki indicate that every patient including those of a control group, if any, should be assured of the best proven diagnostic and therapeutic method. Of particular importance to be considered in the placebo-controlled study, and in the use of investigational drugs in general, is the role of the third-party payer. A growing number of insurance companies, particularly in managed care, will not pay for drug therapy intended for investigational use (18). One way to answer whether or not placebo group is ok is to insist that placebo studies be done only when there is no other way to acquire information of vital importance for subjects with particular ailments and conditions.

The ethical problems are further compounded by the dilemma of whether to switch all participants to what appears, at the time, to be the

most effective treatment. The benefit of not doing so is to obtain further evidence that what seems to be more effective, really is. The drawback is that some patients, for that study, may not receive the better treatment. Of course, reality tempers all these considerations. Patients often drop out if treatment does not work or, paradoxically, if it works so well they no longer feel the need for treatment. There are no simple solutions to these problems. What is important, however, is awareness that the problems exist and require consideration. Fortunately, most studies in psychiatric research involve minimal physical risk or discomfort, and most psychiatrist-researcher have sufficient insight into their own motives and feeling to discharge both duties appropriately (18, 20).

Conclusion

Mental disorders are highly common conditions with significant morbidity yet only modestly effective treatments. For finding new treatments for major depression, obsessive compulsive disorder, or schizophrenia, for example, the suffering and loss caused by these diseases call for the development of truly novel interventions. Investigating new medications can carry risks of significant harm even while raising hopes for future profit (20). In addition, the very nature of many psychiatric disorders creates ethical complexity because many persons with such disorders have deficit memory. If a patient's cognition impairment is severe enough, she or he will be incompetent to give informed consent for research. Publication of patient records; risky experimental use of placebo; scientifically necessary but dangerous "wash-out" periods in clinical trials; and contribution of potentially defenseless, decisionally "incapable" patients have stimulated argument, threatening the continuation of some psychiatric research activities (10).

References

1. Wettstein RM. Research ethics and human subjects. *Psychiatr Res Rep* 1995; 10: 1–14.
2. Eichelman B, Wikler D, Hartwig A. Ethics and psychiatric research: problems and justification. *Am J Psychiatry* 1984; 141: 400–5.
3. Fulford KW, Howse K. Ethics of research with psychiatric patients: principles, problems, and the primary responsibilities of researchers. *J Med Ethics* 1993; 19: 85–91.
4. Oldham JM, Haimowitz S, Delano SJ. Protection of persons with mental disorders from research risk: a response to the report of the National Bioethics Advisory Commission. *Arch Gen Psychiatry* 1999; 56: 688–93.
5. Kantor JE. Ethical issues in psychiatric research and training. In: *Annual Review of Psychiatry*; Vol 13, edited by Oldham JM, Riba MB. Washington, DC: American Psychiatric Press Inc; 1994, pp. 343–64.
6. Sider RC. Ethics, in *Core Readings in Psychiatry: An Annotated Guide to the Literature*. 2nd Edition, edited by Sacks MH, Sledge WH, Warren C. Washington, DC: American Psychiatric Press Inc; 1995.
7. Hirschfeld RM, Winslade W, Krause TL. Protecting subjects and fostering research. Striking the proper balance. *Arch Gen Psychiatry* 1997; 54: 121–3.
8. Anonymous. Principles of Informed Consent in Psychiatry. <http://www.psych.org/search.aspx?SearchPhrase=%22Principles+of+Informed+Consent+in+Psychiatry%22> (accessed on 2008)
9. Carpenter WT JR, Gold JM, Lahti AC, et al. Decisional capacity for informed consent in schizophrenia research. *Arch Gen Psychiatry* 2000; 57: 533–8.
10. Eichelman B, Wikler D, Hartwig A. Ethics and psychiatric research: problems and justification. *Am J Psychiatry* 1984; 141: 400–5.
11. Schwartz V, Appelbaum PS. Improving the quality of informed consent to research. *IRB* 2008; 30: 19-20.
12. Appelbaum PS. Consent and coercion: research with involuntarily treated persons with mental illness or substance abuse. *Account Res* 1995; 4: 69-79.
13. Kim SY, Appelbaum PS, Jeste DV, Olin JT. Proxy and surrogate consent in geriatric neuropsychiatric research: update and recommendations. *Am J Psychiatry* 2004; 161: 797-806.
14. Kim SY, Appelbaum PS, Swan J, et al. Determining when impairment constitutes incapacity for informed consent in schizophrenia research. *Br J Psychiatry* 2007; 191: 38-43.
15. Appelbaum PS, Lidz CW, Klitzman R. Voluntariness of consent to research: a conceptual model. *Hastings Cent Rep* 2009; 39: 30-9.
16. Anonymous. National Commission 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. Washington, DC: US Government Printing Office; 1979.
17. Anonymous. Ethical principles and practices for research involving human participants with mental illness. *Psychiatr Serv* 2006; 57: 552-7.
18. Miller FG. Placebo-controlled trials in psychiatric research: an ethical perspective. *Biol Psychiatry* 2000; 47: 707–16.
19. D'Souza DC, Krystal JH. Psychopharmaceutical challenge studies in psychiatric research. *Int Rev Psychiatry* 2001; 13: 40–6.
20. Weijer C. Research involving the vulnerable sick. *Account Res* 1999; 7: 21–36.