Workshop Report

The therapeutic misconception, decision making and informed consent: the ethics of trial participation for neuromuscular disorders.

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This debate at the 'Bringing Down the Barriers' conference, November 2009 presented the following motion:

Parents who express hope in the possibility of therapeutic benefit from clinical trial participation should not be allowed to consent for their children to enter trials.

1 Supporting the motion

The therapeutic misconception arises when individuals do not understand that the defining purpose of clinical research is to produce generalisable knowledge, rather than benefit them personally [1]. Perhaps the most profound ethical principle to arise from the Nuremberg Code and the Declaration of Helsinki is that only those able to give their free and informed consent should be exposed to the risks of a trial [2], [3].

Trial co-ordinators should ensure that participants are adequately informed and have given their consent to take part freely and conditionally, and those empowered to make decisions for others, such as parents for children, also have a moral duty to ensure that their decision is informed and un-coerced. It is absolutely necessary that those consenting have adequate understanding of methods such as "randomisation", "blinding" and "placebo" and they must be able to distinguish the researcher as a scientist, from the clinician as a primary medical carer, if this is the same individual or group.

Research for NMDs often involves parents consenting for their children and it may be difficult to separate the best interests of the child and the parents' interests in the child. In a recent

study of parents of children with DMD taking part in trials, Henderson reported that parents often find it difficult to distinguish between their doctor's advice as a clinician and their doctor acting as researcher [4], assume that information given is offered in their child's best interests. As one mother relates, "I think that when they describe something for a trial…it always sounds like it is going to be beneficial because otherwise no-one is going to do it. They make it sound like it might do some good." (ibid p115)

The responsibility of the researcher to inform, counsel and support the parent faced with making a decision about trial participation, is paramount. However the harsh but unavoidable conclusion is that if the parent holds the therapeutic misconception then they cannot meet the requirement to give a free and *informed* consent and as such the child should not be permitted to participate in research.

2 Opposing the motion

There should be concern that informed consent is given undue emphasis in the conservative position presented above. The most that should be expected is that researchers use their best endeavours to ensure research participants are provided with relevant information, honestly and in a non-manipulative manner. The imperfect best should sometimes be considered good enough.

If securing informed consent is seen in a legalistic way, as an abstract, procedural or rational manner of decision making, there is the risk that virtually no-one would qualify to be able to give informed consent to research. It is impossible to separate the emotional from the rational and this is as true for clinician and researchers as it is for patients and parents. Having some hope that there might be some sort of benefit to the individual from research is not a disqualification from rational thinking. Hope is a necessary condition of the human spirit Bearing in mind that consent may well be imperfect, perhaps we should consider that consent is not the single ethical key to unlock access to participation in research.

Potential research participants need information, support and counselling and it is the researcher's responsibility to meet those needs while not being unduly paternalistic about whether particular individuals should be involved in the research or not. We know that technical language can be conveyed in an accessible format and can be independently assessed. In addition, the degree of expertise that patients and their carers gain over time about these particular conditions and sophisticated concepts must not be underestimated. This is in a context where it must be acknowledged that participation will, to a lesser or greater extent, be motivated by a number of internal and external drivers that strictly

undermine a valid consent in its legal sense. This can be compensated for by taking into account the reasonable expectation that we should all participate in research. This is not an argument for abolishing consent rather that we should recognise and be realistic about its limitations and seek an informed consent which is more socially nuanced.

3 The Debate – a selection of points

If the debate motion were taken to its logical end the conclusion arrived at would be that, only parents who do not express hope in the possibility of therapeutic benefit from clinical trial should be allowed to consent for their children to enter trials. Such a person would be impossible to find.

Therapeutic misconception affects the whole community and is taken advantage of by researchers in order to advance science more quickly. Some large trials only successfully recruit because of the hope for potential benefit and it is unreasonable for researchers to try to quash or take away that potential. However, some researchers are guilty of introducing the therapeutic misconception with pre-clinical studies and they should be cautious about such claims [5].

Parents might have multiple reasons for allowing their child's participation and nobody has the right to judge what a person's motivations are for wanting to participate or for wanting their child to participate. Due to the context surrounding a decision to enter a trial, parents are in a very stressful situation and may be fragile, but that does not necessarily affect their ability to weigh up a situation and assess risk and benefit.

There often exists a very specific and unique relationship between a patient, the family and their clinician built up over many years, during which time the clinician only ever acts in the patient's best interests. This relationship can lead to confusion if the clinician is the person who first approaches the patient about trial participation. There was the suggestion then that the introduction of an independent person to deal with consenting for trials is something which should be discussed within the field.

4 Conclusion

In preparation for this debate a number of ideas were put forward on developing a more social form of consent, which treats consent as a process rather than a single act and provides those involved with ongoing psychosocial support including things like, access to psychologists, peer-to-peer support and play therapy for children.

The therapeutic misconception does not show parents or patients to be incapable of making decisions to participate in research, it shows that, if we take seriously the challenge of informing and supporting people in making their own decisions, then the process is a complex one. Professional and patient communities need to work together to ensure that clinicians and trial co-ordinators avoid paternalism and parents and patients approach trials with informed hope rather than unrealistic expectations.

Speakers: Lynn Hagger (Sheffield, UK); Gordon McClurg (Newcastle upon Tyne, UK); Pauline McCormack (Newcastle upon Tyne, UK); Patrick Moeschen (Salem, NH, USA); Maryze Schoneveld van der Linde (Baarn, the Netherlands); Tsveta Schyns (Brussels, Belgium); Volker Straub (Newcastle upon Tyne, UK); Elizabeth Vroom (Amsterdam, the Netherlands); Simon Woods (Newcastle upon Tyne, UK).

Contributors from audience: Karl Bettleheim (UK); Nic Caitlin (UK); Elizabeth McNeill (USA); Boris Sustaric (Slovenia); Kevin Flanigan (USA); Francesco Muntoni (UK); John Porter (USA); Brian Tseng (USA); Bruce Wentworth (USA); B R Lakshmi (India); Pat Furlong (USA).

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