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The Emergency Research Waiver of Consent Rule: Is It Compatible with Catholic Teaching?

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With the advent of cardiac resuscitation and mechanical ventilation in the 1970s, researchers sought to find better and more effective treatments and techniques for stabilizing and treating individuals who have injuries or illnesses that can rapidly lead to irreversible physiologic decline and death. Innovations in emergency medical treatment have focused attention on research without consent in randomized clinical trials involving high-pressure and time-sensitive situations. When confronted with a rapidly progressing and potentially life-threatening medical condition, taking the time to explain a protocol or treatment and then obtain informed consent would endanger the patient. Moreover, individuals in such physiologic extremis do not have the capacity or the ability to consent. If family members are available at the time of the emergency, consent may be obtained from them, but this may also be difficult because they too are likely suffering psychological distress. And frequently, treatment must be started immediately by Emergency Medical Services (EMS) personnel because time is of the essence in providing effective treatment.

1. Terri A. Schmidt, MD et al., Confronting the Ethical Challenges to Informed Consent in Emergency Medicine Research, 11 ACAD. EMERG. MED. 1082 (October 2004).
While it may be appropriate to presume consent in emergency medical treatment contexts in order to promptly provide beneficial medical care to the patient, it is more difficult to justify research without consent where the primary purpose is to benefit society rather than the individual patient. Nonetheless, in 1996, the Food and Drug Administration (FDA) adopted the Emergency Research Waiver of Consent (ERWC) rule and simultaneously the Department of Health and Human Services announced it was waiving informed consent for research that complied with the FDA rule. While some have criticized the ERWC rule and particularly its reliance on community consultation, others have argued that it provides adequate safeguards and is justified by the potential benefit to society.

The primary purpose of this paper is to provide an introduction to this issue for Institutional Review Board (IRB) members at Catholic institutions, Catholic researchers, and IRB members at non-Catholic institutions who happen to be Catholic. There are undoubtedly ongoing trials already approved under the ERWC rule involving Catholic hospitals, and there are likely to be more in the future. We will begin with a brief review of a few multisite trials conducted under the ERWC rule. We will provide a brief overview of the law governing informed consent in the medical treatment context and then turn to the development of the international and domestic legal regimes governing informed consent in the research context. We will then turn to the ERWC rule reviewing the main arguments against it, and discussing its compatibility with Catholic teaching. Under some circumstances, studies conducted under the ERWC rule could be inconsistent with Catholic moral teaching, and IRBs at Catholic institutions should carefully scrutinize protocols submitted under it.


6. As noted in § II.3.B., infra, Institutional Review Boards are required to review emergency research protocols under both the common rule promulgated by DHHS and followed by many other federal agencies and under the FDA rules.
I. AN OVERVIEW OF SOME MULTI-SITE TRIALS

Although initially there were relatively few protocols approved under the ERWC rule, in recent years there has been a substantial increase in the number of trials and participants. Nonetheless, some researchers believe the ERWC rule is still too burdensome, and IRBs are hesitant to approve protocols due to fear of liability. The following provides a brief summary of some larger trials.

One of the most notable protocols approved was the Public Access Defibrillation (PAD) Trial, a study involving the use of cardiopulmonary resuscitation (CPR) alone or CPR plus use of an Automated External Defibrillator (AED) by lay volunteers awaiting arrival of the community’s emergency medical services responders. This multicenter, randomized trial involved 1,000 community sites (e.g., shopping malls, apartments, senior centers, sports facilities) in the United States and Canada. The primary purpose of the trial was to determine whether the use of properly trained AED responders in urban settings could increase the numbers of cardiac arrest survivors to hospital discharge, and Gillenwater reports that as of 2008 it was the only completed trial reporting statistically significant positive results.

8. Biros, supra note 5, at 551.
10. The National Heart, Lung, and Blood Institute website notes: An automated external defibrillator (AED) is a portable device that checks the heart rhythm. If needed, it can send an electric shock to the heart to try to restore a normal rhythm. AEDs are used to treat sudden cardiac arrest (SCA)... if trained personnel aren’t available, untrained people also can use an AED to help save someone’s life. You often find AEDs in places with many people, such as shopping malls, golf courses, businesses, airports, airplanes, casinos, convention centers, hotels, sports venues, and schools. You also can purchase a home-use AED.
12. Id.
Patients have also been the subjects of emergency medical treatment research in several multi-site trials sponsored by the Resuscitation Outcomes Consortium (ROC). The ROC trials are a series of studies of emergency treatments for severe traumatic injury and cardiac arrest. There are 11 ROC sites (eight in the United States and three in Canada). The first ROC study involved 6,000 patients/subjects that had sustained head trauma. One arm of this study received saline infusions to stabilize blood pressure (standard care) while the other arms received a hypertonic infusion containing much higher levels of sodium either with or without a drug named Dextran. This study was stopped after it was determined that the hypertonic saline solutions worked no better than the standard care.

The second ROC study involved 15,000 victims of sudden cardiac arrest. Patients in one arm of this study received a shock to the heart before CPR was administered, while the other arms first received a few minutes of CPR either with or without a special valve device to push air into the lungs during the CPR. The enrollment in this trial was stopped when the preliminary data indicated that neither strategy significantly improved survival.

There are also a number of current ROC studies including a multi-site study involving 23,600 out-of-hospital cardiac arrest patients treated by EMS personnel comparing survival rates of those in one arm being administered standard CPR (the American Heart Association recommended standard care) with those in the other arm being administered Continuous Chest Compression.

The controversial PolyHeme study was another large, multi-site trial. It involved the use of a hemoglobin-based oxygen carrier

14. See Dutton, supra note 2, at 1106.
17. Stein, supra note 15.
20. Id.
manufactured by Northfield Laboratories. The protocol for the PolyHeme study was approved by the FDA under the ERWC rule and under a Special Protocol Assessment (SPA) that sets up a fast track for the approval of protocols where the experimental treatment has no existing alternatives. Phase II trials showed improved survival from the use of PolyHeme in cases involving extreme endogenous hemoglobin deprivation. Accordingly, the FDA approved a phase III trial involving 720 hemorrhagic shock victims that was to be conducted at 32 trauma centers in the United States from 2006–2007.

The PolyHeme trial included both a pre-hospital phase and an in-hospital phase and enrollment occurred in the field before arrival at the emergency room. While it was unlikely that consent could be obtained in the field, upon arrival at the hospital efforts were to be made to obtain consent from the patient or a legally authorized representative (LAR). But absent formal withdrawal, participation was to be continued by default. In the pre-hospital phase, patients were randomized between a control group that was given saline, the current standard of care, and the group that was given PolyHeme. During the in-hospital phase, those patients that had received saline were given whole blood (the standard care), but patients in the PolyHeme arm continued to receive it rather than whole blood for up to 12 hours after arrival at the hospital.

The controversial part of the trial was the continued use of PolyHeme after hospital admission. Kipnis et al. (2006) argues that while there was justification for a randomized clinical trial comparing whole blood with PolyHeme in the pre-hospital phase, the use of transfused whole blood in the hospital setting was a “proven and satisfactory treatment,” and accordingly use of PolyHeme during the in-hospital phase required the informed consent of the patient or an

24. Id.
25. Id.
27. Id. at 19. See also 45 C.F.R § 46.102(c) (“Legally authorized representative 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.”).
28. Kipnis, supra note 26, at 18.
29. Apte, supra note 23, at 60.
30. Apte, supra note 23, at 60
LAR. On the other hand, Dougherty (2006) argues that the protocol was appropriate under the ERWC rule because transfusion with banked blood is not a satisfactory treatment due to its link with increased incidence of multi-organ failure. And Silbergeit et al. (2006) argues that whole blood is an "unsatisfactory" treatment noting that it is in short supply, has adverse side effects, 35 percent of patients that receive it still die, and those who refuse it may still survive.

Northfield was also criticized for not disclosing the study protocol at the community meetings. The PolyHeme study did not achieve statistically significant results although the death rate was slightly higher in the group receiving PolyHeme, and it was shut down by Northfield after Senator Charles Grassley (R-Iowa) sent letters to the FDA and DHHS expressing concern that the trials were unethical.

II. THE DOCTRINE OF INFORMED CONSENT

A. DEVELOPMENT OF DOCTRINE IN THE TREATMENT CONTEXT

Beginning in the 1950s with Salgo v. Leland Stanford Jr. Hospital, courts in the United States began to recognize a cause of action for lack of informed consent in the treatment context based on negligence. "It was Salgo that finally shifted patient consent in clinical settings from being beneficence-based (doing surgery without patient consent 'hurts' the patient) to autonomy based (a patient has a right to self-determination through informed, comprehensive consent)." Under the doctrine of informed consent, physicians are

31. See Kipnis, supra note 26.
34. Kipnis, supra note 26, at 19.
35. Gillenwater, supra note 7, at 237; see also Thomas M. Burton, Amid Alarm Bells, A Blood Substitute Keeps Pumping, WALL ST. J., Feb. 22, 2006 (stating that an additional troubling aspect of the PolyHeme trial was the failure of Northfield to publicly disclose an earlier trial that was shut down after ten of 81 patients had suffered heart attacks and two of those died within seven days of receiving PolyHeme while none of the patients in the trial that had received whole blood suffered a heart attack).
supposed to provide the patient with information on the nature of the treatment, its risks, and appropriate alternatives.\footnote{View, in Bioethics and Society: Sociological Investigations of the Enterprise of Bioethics 38, 51(1998).}

Although the origins of the informed consent doctrine are in battery, most jurisdictions have now adopted negligence as a more appropriate basis for causes of action for lack of informed consent.\footnote{W. Page Keeton et al., Prosser & Keeton On Torts 190 (5th ed. 1984).} When this shift to negligence occurred, courts began to treat informed consent actions as conventional medical malpractice cases.\footnote{Marjorie Maguire Schultz, From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L.J. 219, 224–26 (1985).} Accordingly, like other malpractice cases the focus was on the professional standard, i.e., whether the defendant physician in failing to provide information to the patient had acted in accordance with accepted practices in the medical profession. Under this standard, the plaintiff seeking to recover for lack of informed consent is required to provide expert medical testimony as to whether the physician violated professional custom in failing to provide adequate information to the patient.\footnote{See, e.g., Natanson v. Kline, 350 P.2d 1093 (Kan. 1960).}

Subsequently, however, several courts rejected the professional standard and instead embraced a prudent patient standard under which physicians are required to provide patients with information that a reasonable, prudent patient in similar circumstances would deem material to a decision to consent to treatment.\footnote{Leonard J. Nelson, III, Consent to Treatment in David W. Louisell & Harold Williams, Medical Malpractice § 22.05[2] (2011).} Under either standard, however, patient autonomy is only partially protected because most courts follow an objective standard of causation that requires the patient to prove that a reasonable, prudent patient when informed of the risk would have refused the treatment.\footnote{Id at § 22.05[3]; see also Peter H. Schuck, Rethinking Informed Consent, 103 Yale L.J. 899, 916 (1994).} Further, only patients that have suffered an adverse outcome from the undisclosed risk have a cause of action against their physician.\footnote{Schultz, supra note 39, at 227. Schuck, supra note 42, at 925–26.}

The requirement of informed consent in the treatment context has now been recognized by the American Medical Association as a basic principle of medical ethics.\footnote{American Medical Association, Code of Medical Ethics, §§ 2.07 and 8.08 (Chicago, IL,}
acceptance, some contend that informed consent has had only limited success in meeting the needs of patients because physicians have resisted sharing decision-making authority with patients.46 Others are skeptical of the value of informed consent,47 and some studies suggest that most patients do not understand and do not retain the information provided to them.48

It is generally recognized that the informed consent of the patient is not always required in the treatment context. For example, if a patient becomes incapacitated, treatment decisions may be made by a surrogate decision-maker, i.e., a third person who has the authority to make medical decisions for an incapacitated patient. All states have adopted laws permitting a legally competent individual to execute a document authorizing a proxy to make healthcare decisions on behalf of a patient after the patient loses decision-making capacity.49 When there is no proxy or a guardian with authority to make medical decisions, many states have adopted statutes designating the patient’s spouse, then adult children, then parents or siblings, to act as the patient’s surrogate decision-maker.50 And even in the absence of such a statute, physicians typically presume that close family members who know the patient have decision-making authority.51

Moreover, in the case of medical emergencies where a delay could cause serious harm to the patient, courts have recognized that if the patient is unable to consent and a surrogate decision-maker is not readily available, then informed consent to treatment is presumed.52 Generally, the scope of consent in these situations is limited so that “the extent of the intervention should be proportionate to the

1997).


50. Id. at § 8.01.

51. Id. at § 3.16[C][1].

emergency itself." But, as discussed infra, it is more difficult to justify research without consent than treatment without consent.

B. DEVELOPMENT OF DOCTRINE IN THE RESEARCH CONTEXT

The doctrine of informed consent emerged in the clinical research context before it was recognized in the treatment context. The United States has taken a leading role in the development of international and domestic normative frameworks emphasizing the importance of informed consent of subjects in justifying their participation in clinical research trials. Although it is viewed primarily as a method of fostering human dignity and autonomy, informed consent also serves as an additional safeguard against unethical experiments. As noted infra, many poorly designed experiments with endpoints of death or serious injury have been conducted without obtaining informed consent. These experiments could not be ethically justified even with informed consent, but the failure to require informed consent certainly facilitated their conduct.

In the development of these norms, policymakers have generally attempted to strike an appropriate balance between the competing desires to protect human dignity and foster scientific advances. But despite attempts at regulation there have been numerous unfortunate and notorious instances of researchers, some conducting clinical trials with support of agencies of the United States government, failing to protect the rights of research subjects. Frequently, these unethical trials were motivated by national security concerns.

1. The International Legal Framework

The two most significant documents in the international context are the Nuremberg Code and the Helsinki Declaration. Ironically, prior to World War II, Germany was a leader in regulating human subject research. The necessity of obtaining informed consent in research trials had emerged as an issue in Germany in the 19th century. Thus "at the turn of the century informed consent was

53. Capron, supra note 52, at 20.
54. Wolpe, supra note 37, at 51
already a legal doctrine in medical experimentation in Germany, being based on 'unambiguous consent' of the subject after 'proper' information had been given by the doctor, including negative consequences and side effects.' In 1931, Germany enacted binding regulations governing human subject research that were in some ways stricter than the later Nuremberg Code. Although they were ignored by the Nazis, these regulations remained in effect until 1945. These regulations required informed consent to experimental treatments except in cases where it is "urgently required, and cannot be postponed because of a need to save life or prevent severe damage to health, and if prior consent could not be obtained owing to special circumstances." 

Notwithstanding these antecedents, accounts of the history of the regulation of human subject research typically begin with the trial of Nazi doctors by the victorious allies and the promulgation of the Nuremberg Code. Walter Beals, an army reserve officer on leave from his position as Chief Justice of the Supreme Court of Washington, presided over this trial. Twenty-three physicians were tried for war crimes and crimes against humanity for their involvement in unethical and frequently fatal medical experiments: sixteen were convicted and seven were hanged. In rendering its verdict the court adopted the Nuremberg Code (1947), which laid down ten standards for ethical conduct in conducting medical research on human beings. The first principle of the Nuremberg Code states: "The voluntary consent of the human subject is absolutely essential." 

As Garnett (1996) has noted, the Nuremberg informed consent standard has been criticized as being too demanding and not

57. Id.
59. Id. at 104.
60. Id. at 105.
sufficiently deferential to the necessity of human experimentation in medical progress.65 Others have noted that it has never been fully embraced by the international community.66 Nonetheless, although the United States has “never ratified or adopted the Nuremberg Code,”67 the Second Circuit has recognized its prohibition on nonconsensual medical experimentation as a universally accepted norm of customary international law.68

The Helsinki Declaration of the World Medical Association, first issued in 1964 and subsequently revised on several occasions, is less absolute in its requirements than the Nuremberg Code. It requires that “subjects must be volunteers and informed participants in the research project.”69 But it does accept the notion of surrogate consent.70 The current version also provides for research without consent under some circumstances.71 The Helsinki Declaration has had a greater influence on domestic laws than the Nuremberg Code and has been recognized as binding customary law.72 Nonetheless, in 2008, acceding to the request of pharmaceutical manufacturers, the FDA removed its requirement that foreign clinical trials conducted without an investigational new drug (IND) application73 had to

67. Abdullahi, 562 F.3d at 176 (noting that “[a] formal treaty . . . is not the lone primary source of customary international law.”).
68. Id. at 183–84.
70. Id. at ¶ 15.
71. Id. at ¶ 17.
72. Abdullahi, 562 F.3d at 181–82.
73. The FDA website notes:

Current Federal law requires that a drug be the subject of an approved marketing application before it is transported or distributed across state lines. Because a sponsor will probably want to ship the investigational drug to clinical investigators in many states, it must seek an exemption from that legal requirement. The IND is the means through which the sponsor technically obtains this exemption from the FDA.

comply with the Helsinki Declaration and instead substituted a requirement that the trials be conducted in accordance with good clinical practices and reviewed by an independent ethics committee. 

2. The Persistence of the "Dachau Model"

Researchers have tended to view the Nuremberg Code's informed consent requirement as too demanding, and compliance with it has frequently been subordinated to the demands of national security by United States government agencies because of the value of information to be gleaned from the "Dachau Model" of human subject research. After World War II, the United States government sought to reap the benefits of unethical experiments conducted by both the Japanese and German military doctors. In order to obtain information on biological warfare research and keep it out of the hands of the Soviet Union, the United States government refused to prosecute members of the Japanese Army's notorious Unit 731 who had conducted atrocious medical experiments during World War II. Subsequently, in the 1950s the United States Air Force recruited Nazi doctors who had been involved in unethical altitude sickness and hypothermia experiments involving Dachau prisoners to start its aviation medicine school in Texas and published an account of their research.

During the Cold War, agencies of the United States government supported and conducted numerous radiation experiments for purposes related to national security. Hospitalized patients were injected with plutonium without their consent for the purpose of obtaining knowledge to better protect workers involved in the production of material for nuclear weapons. At the University of Cincinnati, terminally ill cancer patients were subjected to total body irradiation without their knowledge in experiments supported by the

(Continued from previous page)

process/howdrugsaredevelopedandapproved/approvalapplications/ investigative/newdrugapplication/default.htm (last visited October 14, 2012).


77. McCoy, supra note 75, at 403.

78. ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS, FINAL REPORT 36–37 (October 1985).

79. Id. at 264–69.
military to "find a biological dosimeter and provide additional human performance data of military interest." 80 There were numerous intentional releases of radiation into the environment without notice to affected populations. 81 These releases included the infamous Green Run where radioiodine was intentionally released from the Hanford nuclear facility in Washington State to "develop intelligence techniques to understand the threat posed by the Soviet Union." 82 Prevailing winds carried radioiodine over eastern Washington and levels were monitored to determine levels of radioactive material in the air, water, and vegetation. 83 Information on the Green Run remained classified until 1986. 84 With respect to these experiments, Dr. Katz noted:

My reading of the Cold War record suggests that governmental officials in concert with their medical advisers at best paid lip service to consent. Whenever they considered it, they worried mostly about legal liability and embarrassment. They were not worried or embarrassed about their willingness to conscript unconsenting patient-subjects to serve as means in plutonium and whole body radiation experiments. All this is a frightening example of how thoughtlessly human beings, including physicians, can treat human beings for ‘noble’ purposes. Most references to consent (with rare exceptions) that we uncovered in governmental documents or in exchanges between officials and their medical consultants were meaningless words, which conveyed no appreciation of the nature and quality of disclosure that must be provided if patient-subjects were truly to be given a choice to accept or decline participation in research.

Form, not substance, punctuated most of the policies on consent during the Cold War period. The drafters of the federal regulations would eventually build their rules on this shaky historical foundation, disregarding in the process that the imprecision of their

80. Id. at 386–87.
81. Id. at 506.
82. Id. at 509
83. Id. at 510.
84. ADVISORY COMMITTEE ON HUMAN RADIATION EXPERIMENTS, supra note 78, at 510.
policies invited physician-investigators not to alter decisively customary Hippocratic practices. There is also evidence of pervasive Central Intelligence Agency (CIA) support for unethical psychological research during the Cold War that involved prominent researchers. In 1966, a landmark article by Harvard Professor Henry Beecher exposed research abuses in trials conducted in the United States and particularly drew attention to the failure to obtain informed consent in several studies. Observing that informed consent had been mentioned in only two of the fifty published studies he reviewed, Beecher argued that it should be obtained in all studies for legal and moral reasons. He was, however, skeptical of its efficacy opining that “[c]onsent in any fully informed sense may not be obtainable[,]” and further that “it would be unrealistic to place much dependence on it.” But it now appears that Beecher may have been involved in CIA-sponsored research conducted in Germany during the Cold War that involved the use of psychotropic drugs “on unwitting human subjects.” This research may have been inspired by the use of mescaline to interrogate inmates at Dachau. Ironically, Beecher thought the presence of a “responsible investigator” to “be a far more dependable safeguard” than informed consent.

In 2010, while conducting research on the Tuskegee Study, Susan Reverby, a medical historian from Wellesley happened on evidence that the United States Public Health Service conducted research in Guatemala in the 1940s that involved deliberately infecting Guatemalans with venereal diseases. Subsequently, in 2011, during hearings on the Guatemalan research before the Presidential Commission for the Study of Bioethical Issues (the

85. Id. at 850.
86. See McCoy, supra note 75; but see Thomas Blass, Unsupported Allegations About a Link Between Milgram and the CIA: Tortured Reasoning in A Question of Torture, 43 J. OF THE HIST. BEHAV. SCI. 199 (2007) (disputing McCoy’s allegation that Milgram’s obedience research was funded by the CIA); Richard E. Brown, Alfred McCoy, Hebb, the CIA and Torture, 43 J. OF THE HIST. BEHAV. SCI. 205 (2007) (disputing the allegation that Donald O. Hebb, Chair of Psychology at McGill University, was involved in special interrogation research).
88. Id. at 1355.
89. Id.
90. McCoy, supra note 75, at 410–14.
91. Id.
92. Id.
"Presidential Commission"), it was revealed that from 1946–1948, the United States Public Health Service supported experiments where Guatemalan prostitutes infected with syphilis were paid to have sex with prisoners.\textsuperscript{94} And in some cases, if this was not sufficient to infect the men, "bacteria were poured into scrapes made on the penises or faces, or even injected by spinal puncture."\textsuperscript{95}

Approximately 5,500 Guatemalans were involved in these experiments and approximately 1,300 "were deliberately infected with syphilis, gonorrhea or chancroid."\textsuperscript{96} The purpose of the study was to determine whether the administration of penicillin after exposure could prevent infection.\textsuperscript{97} One of the researchers involved in this study was John C. Cutler, a former Assistant United States Surgeon General who had served as the Acting Dean at the School of Public Health of the University of Pittsburgh in 1968–1969, and was also involved in the Tuskegee Study, discussed infra.\textsuperscript{98}

The Presidential Commission’s report on the Guatemalan experiments noted that one of the motivating factors in conducting this research was to enhance military efficiency by reducing the prevalence of STDs among members of the armed forces.\textsuperscript{99} The Presidential Commission found an intentional disregard by the researchers of "generally accepted moral principles."\textsuperscript{100} It noted that the research originated in the same government laboratory and involved some of the same researchers as the Tuskegee study.\textsuperscript{101} The experiment was carried on despite the knowledge of the researchers that it violated "existing basic ethical standards" in order "to serve scientific and government ends."\textsuperscript{102} The Presidential Commission found "there is no evidence that consent was sought or obtained from the individual subjects who were the subjects of the research. On the

\begin{itemize}
\item \textsuperscript{95} Id.
\item \textsuperscript{96} Id.
\item \textsuperscript{97} Id.
\item \textsuperscript{100} Id. at 8.
\item \textsuperscript{101} Id. at 3.
\item \textsuperscript{102} Id. at 7.
\end{itemize}
contrary, there were examples of active deceit."\(^{103}\) The Presidential Commission concluded that the research was “morally wrong” and the researchers involved were “morally blameworthy.”\(^ {104}\) It also concluded that researchers had violated the Nuremberg Code.\(^ {105}\) The report opined: “The events in Guatemala serve as a cautionary tale of how the quest for scientific knowledge without regard to relevant ethical standards can blind researchers to the humanity of the people they enlist into research.”\(^ {106}\) Certainly, the persistence of the Dachau Model despite the promulgation of the Nuremberg Code suggests a need for continuing vigilance and focus on the necessity of informed consent to protect research subjects.

3. United States Domestic Law

In the 1960s, there were efforts in the United States to strengthen the domestic legal oversight of human subject research. These legal reforms were typically undertaken in response to exposés of research misconduct. For example, in 1962, in response to the Thalidomide scare, the 1962 Kefauver-Harris Amendments to the Food, Drug and Cosmetic Act of 1938 strengthened oversight of drug trials by requiring that manufacturers establish both the safety and efficacy of drugs. This legislation was occasioned by the attempts of the drug’s manufacturer to pressure employees of the Food and Drug Administration to approve Thalidomide despite inadequate supporting scientific studies to establish its safety.\(^ {107}\) As part of this legislation, there was a requirement of informed consent in drug trials.\(^ {108}\) But this legislation was “largely ineffective” due to “broad exceptions where obtaining consent was ‘not feasible’ or not in the best interests of the subjects.”\(^ {109}\) Subsequently, in 1966, the Surgeon General issued a directive requiring research supported solely by the government to be peer reviewed in order to ensure protection of the

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103. Id. at 92.
104. Id. at 8.
106. Id. at 7.
108. Id.
rights of research subjects and the use of appropriate methods of obtaining informed consent.\textsuperscript{110}

In the 1970s, significant steps were undertaken in the United States to strengthen protection for research subjects in response to public revelation of the Tuskegee syphilis study in 1972. This study was begun under the auspices of the United States Public Health Service in 1932 in rural Macon County, Alabama. The study involved 399 African American males infected with syphilis, and a control group of 201 men from the same community that were not infected. When penicillin became available, the men with syphilis were not provided this treatment.\textsuperscript{111}

In reaction to the exposé of the Tuskegee syphilis study, the Assistant Secretary for Health and Scientific Affairs at the Department of Health, Education and Welfare (HEW), appointed an ad hoc panel to investigate the study. A report issued by the committee concluded that there was no evidence that informed consent had been obtained from the human participants in the study.\textsuperscript{112} It also found that treatment had been withheld from participants.\textsuperscript{113}

Jay Katz, an adjunct member of the committee, believed that the majority report was too timid in its condemnation of the study. Accordingly, he wrote his own opinion noting that, based on the testimony at Nuremberg, the Tuskegee study “would have been intolerable . . . anywhere in the civilized world.” Nonetheless, Katz noted that it continued after the Nazi Doctors trial and the promulgation of the Nuremberg Code and was not reviewed even after the 1966 Surgeon General’s directive was issued.\textsuperscript{114} He further observed, “The most fundamental reason for condemning the Tuskegee Study at its inception and throughout its continuation is not that all the subjects should have been treated, for some might not have wished to be treated, but rather that they were never fairly consulted about the research project, its consequences for them, and

\textsuperscript{110} Id. at 95.
\textsuperscript{112} Id. at 8.
\textsuperscript{113} Id. at 9.
\textsuperscript{114} Id. at 14; see also Jay Katz, M.D., Reservations About the Panel Report on Charge I, available at http://biotech.law.lsu.edu/cphl/history/reports/tuskegee/katz1.pdf (last visited October 14, 2012).
the alternatives available to them."¹¹⁵ Not surprisingly, revelations of the Tuskegee Study reinforced a legacy of mistrust of clinical research in the African-American community.¹¹⁶

In 1974, the Department of Health, Education and Welfare (DHEW) issued new regulations governing Institutional Review Boards (IRBs).¹¹⁷ These regulations moved away from the concept of peer review and instead embraced the concept of local IRBs that would include non-scientific members.¹¹⁸ Peckman notes:

The new regulations emphasized the importance of considering research in the context of community standards. The regulations defined the composition of an IRB as having a minimum of five members and that it should "include persons whose primary concerns lie in the areas of legal, professional, and community acceptability rather than in the conduct of research, development, and services programs supported by the HEW." In order to ensure a diversity of opinion when considering protocols, membership on an IRB could not come from a single professional or lay group. Furthermore, the regulations now protected against an implicit institutional bias and conflict of interest by mandating that a legally convened meeting must include at least one member not otherwise affiliated with the institution.¹¹⁹

The revelation of research abuses in the Tuskegee syphilis study and other studies also led to the passage of the National Research Act of 1974.¹²⁰ This legislation created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (the Commission).¹²¹ In 1979, the Commission published the Belmont Report (the Report) which articulated three basic ethical principles governing research on human subjects:

¹¹⁵ TUSKEGEE SYPHILIS STUDY, supra note 111.
¹¹⁸ Id.
¹¹十九Id. at K-7.
¹²⁰ Goldner, supra note 109, at 96.
¹²¹ Id.
respect for persons, beneficence, and justice. The Report became a foundational document for the new secular bioethics movement despite its philosophical incoherence. One observer noted, "[The Report] quite selectively took bits and pieces from different and contradictory ethical theories and rolled them up into one ball." The principles could contradict each other when applied, and there was no hierarchy among them. Moreover, there are internal contradictions within the Report:

For example, while the Commissioners of The Belmont Report gave a nod to the traditional Hippocratic understanding of "beneficence" in one definition as "doing good for the patient" (or at least, doing no "harm"), their second definition of "beneficence" is essentially utilitarian—in terms of the good for society at large (or roughly, "the greatest good for the greatest number of people.")

The Report distinguishes between medical practice and research: "'practice' refers to interventions that are designed solely to enhance the well-being of an individual patient. and that have a reasonable expectation of success." On the other hand, "'research' designates activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge." With respect to informed consent, the Report delineated three essential components: information, comprehension, and voluntariness. As to information, it opined that both of the malpractice standards (i.e., professional standard and prudent patient standard) are "insufficient" in the research context because "the research subject, being in essence a volunteer, may wish to know

124. Id.
125. Id.
127. Id.
128. Id. at Part C.1.
considerably more about risks gratuitously undertaken than do patients who deliver themselves into the hands of a clinician for needed care." In the case of prospective subjects with limited comprehension, the report acknowledged a role for surrogate decision-makers, but further indicated that those "chosen should be those who are most likely to understand the incompetent subject’s situation and to act in that person’s best interest."

In 1981, the Report led to the adoption of revised regulations governing human subject research in the United States by DHHS and the FDA. In 1991, several federal agencies adopted a uniform set of regulations identical to subpart “A” of the DHHS regulation, and it is now known as the Common Rule. Thus there are now two sets of regulations and that have significant roles in regulating human subject research: the Common Rule and the FDA regulations. Some studies come under both sets of regulations.

The Common Rule is administered by the Office of Human Research Protections (OHRP), formerly known as the Office for Protection from Research Risks (OPRR), within DHHS and establishes the basic structure under which IRBs review research. The Common Rule requires informed consent of the subject or the subject’s legally authorized representative (LAR) in most cases, but permits waiver of consent in minimal risk studies that could not otherwise be carried out. The Common Rule also sets the requirements for approval of research protocols by IRBs. Although it formally applies only to research that is directly conducted or funded by the federal government, in practice its application is much broader: most institutions, pursuant to contractual agreements (assurances) entered into with the federal government, promise to

129. BELMONT REPORT, supra note 122, at Part C.1; see also E. Haavi Morreim, Medical Research Litigation and Malpractice Tort Doctrines: Courts on a Learning Curve, 4 HOUS. J. HEALTH L. & POL’Y 1 (2003).
130. Id.
137. Id. at 106.
140. COLEMAN, supra note 136, at 106.
apply the Common Rule to all research done at their facility regardless of the source of funding.\textsuperscript{141} The FDA regulations also utilize IRBs to review research.\textsuperscript{142} The FDA regulations apply regardless of the source of funding, but only to “clinical investigations” involving drugs, medical devices, and biologics intended for use in human beings.\textsuperscript{143}

Under both sets of regulations, IRBs are charged with the task of reviewing protocols and consent documents. The regulations generally require informed consent, but also provide for some exceptions to this requirement.\textsuperscript{144} But as Dr. Katz has noted, these regulations “still do not satisfactorily protect the rights of patient-subjects to inviolability of personhood and body”\textsuperscript{145} because that would require a radical transformation of “the nature and quality of the conversations between physician-investigators and patient-subjects about participation in research.”\textsuperscript{146} He further states:

The drafters of the federal regulations should have explicitly insisted that taking informed consent seriously in research negotiations obligates physician investigators to spend considerable time with prospective patient-subjects. They should have provided explicit instructions on the length to which investigators must go in explaining themselves and their intentions so that patient-subjects will not be misled. . . . The drafters of the federal regulations insufficiently cautioned physician-investigators against viewing clinical research as an extension of clinical practice.\textsuperscript{147}

IRBs have been criticized for spending too much time focusing on the sufficiency of consent forms and protection from liability rather than on the consent process, and for not giving sufficient scrutiny to the appropriateness of the research protocol.\textsuperscript{148}

\begin{itemize}
\item[141.] Id. at 107.
\item[142.] 21 C.F.R. pt. 56 (2009).
\item[143.] 21 C.F.R. § 56.102 (2009), discussed in Coleman, supra note 136, at 143.
\item[144.] Garnett, supra note 65, at 475, n. 89 (citing 21 C.F.R. § 50.23 (2011) (listing “exceptions from general requirements” of informed consent)); see also 45 C.F.R. §§ 46.116(c), (d) (2005).
\item[146.] Id.
\item[147.] Id. at 24–25.
\item[148.] Garnett, supra note 65, at 478 (criticizing the relative lack of attention paid by IRBs to
In 1998, the Office of Inspector General issued a report criticizing the effectiveness of IRB activities. In recent years, OHRP and the FDA have been somewhat more vigorous in scrutinizing the conduct of clinical trials, citing a number of institutions for violations of federal regulations and even suspending research activities at several.

There have also been a number of tort actions against prominent researchers, academic medical centers, and even individual members of IRBs, alleging research abuses including failure to obtain adequate informed consent. Several of these cases have resulted in settlements.

In July 2011, DHHS issued an advance notice of proposed rulemaking requesting comments on "how to better protect human subjects involved in research, while facilitating valuable research and reducing burden, delay and ambiguity for investigators." The notice states that current practices with respect to consent forms "have been heavily criticized." The notice further states that although the current rules require forms to include eight types of information, they "frequently fail to include some of the most important pieces of information that a person would need in order to make an 'enlightened decision' (to quote the Nuremberg Code) to enroll in a research study," and that the consent forms "often function as sales documents, instead of genuine aids to good decision-making." Moreover, forms have become longer and more difficult to understand. Accordingly, a number of changes are being contemplated, e.g. 1) more specific requirements on content; 2) limits on length; 3) restrictions on inclusion of inappropriate content; 4) reduction in "boilerplate" language; and 5) development of new standardized templates. But of course in an emergency situation,
there is not time to obtain informed consent so these reforms will have no impact on the ERWC Rule.

III. THE ERWC RULE

Generally, the Common Rule requires "legally effective informed consent of the subject or the subject's legally authorized representatives." Under the Common Rule, IRBs are permitted to waive the requirement of informed consent in "research [that] involves no more than minimal risk to the subjects." Prior to 1996, the FDA permitted waiver of consent only where the intervention was necessary to save the life of the subject and held out the prospect of direct benefit, but the DHHS regulations required that the experimental treatment involve no greater than minimal risk. In light of the combined effect of these rules, many researchers believed that Randomized Clinical Trials (RCTs) involving placebos were not permissible in most emergency treatment contexts where patients or proxies were unable to consent because a placebo was not necessary to save the subject's life and more than minimal risk would typically be involved.

159. 45 C.F.R. § 46.116(d) (2005).
161. Id.
162. Id. at 164, 167, and 169. For the history of the randomized clinical trial Ted J. Kaptchuk notes:

World War II has been called the great divide in medical research and certainly, for the placebo, this is true. In fact, the "powerful placebo" was born in the vortex of one of medicine’s most momentous transitions. Before World War II the evaluation of new therapeutics was made by recognised leaders of the medical profession whose judgments were based on clinical impressions, and on rare occasions, poorly controlled evidence. In an effort to impose an objective and scientific discipline onto the extraordinary postwar expansion of medical research, the components of the double-blind RCT were adopted and coalesced in the years after the war. The major features of these innovations included blind assessment (usually meaning a placebo control), random assignment to comparable groups, and inferential statistics as a surrogate for determinism. The postwar placebo effect resulted from an almost sleight of hand shift in the placebo’s operational meaning in the new RCT model. Instead of an inert sham given to individual patients, the placebo became the emblem for all the healing occurring in the disguised “no-treatment” arm of an RCT. The “placebo effect” encompassed all ‘nonspecific effects’ that did not depend on the treatment in the active arm. The “powerful placebo” became a hodgepodge of non-linear, difficult to quantify, remnants collected under the rubric
The ERWC rule was promulgated in reaction to a series of events focusing attention on RCTs involving emergency medical treatments. In 1993, the Office of Protection from Research Risks (OPRR) instructed IRBs to stop approving studies using alternatives to informed consent (e.g., implied consent, deferred consent, and two-tiered consent) "despite their longstanding use in resuscitation research."\(^{163}\) Previously, the FDA had shut down a study of active compression CPR because of concerns about the use of deferred consent and the study design.\(^{164}\) Also, the FDA had denied a waiver of informed consent in an out-of-hospital study of a vest CPR device that had been used in several studies utilizing deferred consent.\(^{165}\) But in 1993, the IRB at the University of Nebraska had obtained approval from the FDA for research without consent in the Polyethylene Glycol Superoxide Dismutase clinical trial, an interventional head injury trial.\(^{166}\)

In 1994, a House sub-committee chaired by Ron Wyden (D-Oregon) held hearings that focused on the confusion that had resulted from the conflict between the FDA and DHHS rules and unethical research practices by some manufacturers.\(^{167}\) Prior to the hearing, the subcommittee issued a report prepared by its staff documenting research abuses in emergency medical treatment trials.\(^{168}\) In response to this report, representatives from the Society for Academic Emergency Medicine (SAEM) entered into a dialogue with Wyden’s staff that resulted in the submission of a consensus statement from

(Continued from previous page)

of the dummy control of an RCT. Anything that threatened the fastidious detection of a predictable cause and effect outcome was conveniently disposed of in a repository labeled the "placebo effect." This new concept of placebo was much larger both in meaning and power than its predecessor. It incorporated many contributors to health outcomes such as natural history, routine medical and nursing care, and the “art” of medicine that had once been clearly distinct from the deception of an inert pill.


163. Biros, supra note 5, at 552; Fost, supra note 160, at 170.

164. Biros, supra note 5, at 552; Fost, supra note 160, at 171.

165. Biros, supra note 5, at 552.

166. Id. at 553.


168. Biros, supra note 5, at 553.
SAEM and the formation of the Coalition of Acute Resuscitation and Critical Care Researchers. The Coalition convened a consensus conference that produced a series of "recommendations that served as a basis for the FDA's final rule."170

The ERWC rule was proposed in September 1995.171 The preamble to the proposed rule noted that many standard emergency medical treatments had "not been evaluated by adequate trials that demonstrate either safety or effectiveness"172 and that some trials had provided evidence that standard treatments were "ineffective or even harmful."173 Thus, the agency was seeking its ERWC rule to provide "access to potentially life-saving therapies" and "improvement of therapies used in emergency medical situations that currently have poor clinical outcomes.174

The final rule was adopted in October 1996.175 Although most of the comments to the proposed rule were positive, the preamble to the final rule noted:

Several objections to the proposed rule noted that the major protection from research risk remains informed consent and that without this procedure, potential abuse of research subjects will always remain unacceptably high; that it is unethical for patients who cannot consent to receive nonstandard care; that overriding individual autonomy and not obtaining informed consent is unacceptable; that therapeutic intent is not sufficient to obviate consent when there are no data or when there is uncertainty or disagreement.176

In justifying the ERWC rule, the preamble argued that the regulation was consistent with the Belmont Report insofar as it

169. Id. at 554.
170. Id.
171. 60 Fed. Reg. 49086 (Sept. 21, 1995).
172. Id. at 49086.
173. Id.
174. Id.
provides additional protections for persons with diminished autonomy including community consultation, public disclosure of the risks and benefits of the trial, public disclosure of the results of the trial, establishing a data monitoring committee to monitor the trial, and opportunity for a family member to object to the subject’s participation in the trial where consent is not feasible and a legally authorized representative is not available within the therapeutic window.177

In order to approve a study under the final ERWC rule, the IRB must find and document all of the following: 1) the subjects are in “life-threatening” situations requiring the contemplated medical intervention; 2) it is not possible to identify prospective subjects in advance; 3) “available treatments are unproven or unsatisfactory;” 4) the research is necessary to determine the safety and effectiveness of the medical intervention; 5) it is not feasible to obtain informed consent from the subject due to his or her medical condition or from the subject’s LAR due to time constraints; 6) there is a prospect of direct benefit to the subjects; 7) the research “could not practicably be carried out without the waiver” of informed consent; and 8) the sponsor is required to commit to attempt to contact the subject’s LAR within the “therapeutic window” to obtain consent.178

Under the FDA version of the ERWC rule, the sponsor is required to submit a separate investigational new drug (IND) application or investigational device exemption (IDE) clearly indicating that the protocol involves research without consent even though there is an existing IND or IDE for the product.179 The FDA must approve the new protocol in writing before the study can begin.180 The DHHS waiver requirements are substantially identical and apply where the research is subject to FDA regulations and carried out under a new IND/IDE. Or, if the protocol is not subject to FDA regulations, the IRB must report to the OPPR (now OHPR) that

177. Id.
it has found and documented that the protocol complies with the FDA regulations.\(^\text{181}\)

The ERWC rule requires "additional protections" for research subjects in emergency medical treatment trials where consent is waived, e.g., 1) consultation with the communities where the research will be conducted and from where the subjects will be drawn; 2) public disclosure to the affected communities of the study design and its risks; 3) public disclosure to affected communities after the completion of the research of its results and "the demographic characteristics of the research population;" 4) an "independent data monitoring board to oversee the research;" 5) where it is not feasible to obtain informed consent from the subject or the subject's LAR within "the therapeutic window," attempting to contact family members; and 6) establishing procedures to inform the subject after the fact of his or her inclusion in the trial (or, where the subject is incapacitated, the subject's LAR or family members), the contents of the informed consent document, and the right to withdraw from the trial "without penalty or loss of benefits."\(^\text{182}\)

In May 2005, a breakout session was held at the Academic Emergency Medicine Consensus Conference that focused on the requirements of the ERWC rule.\(^\text{183}\) This conference resulted in several recommendations: 1) that "life-threatening condition" should be expanded to include serious disability;\(^\text{184}\) 2) it should be permissible to consider existing therapies "unsatisfactory" even if they are "partially effective;"\(^\text{185}\) and 3) IRBs should not grant a waiver in the absence of evidence that the experimental therapy will provide a direct benefit to the patient.\(^\text{186}\) There were also concerns expressed about the "undue barriers to performing important resuscitation research," and "variable or erratic IRB interpretation."\(^\text{187}\) Finally, there was a call for more research on the most effective methods of implementing the community consultation and public notice requirements of the ERWC rule.\(^\text{188}\)


\(^{183}\) Drew Watters, Michael B. Sayre & Robert Silbergeit, Research Conditions that Qualify for Emergency Exception from Informed Consent, 12 ACAD. EMERG. MED. 1040, 1040 (2005).

\(^{184}\) Id. at 1042.

\(^{185}\) Id.

\(^{186}\) Id. at 143.

\(^{187}\) Id.

\(^{188}\) Id.
In March 2011, DHHS and the FDA released additional guidance on the ERWC rule for IRBs, sponsors, and researchers that addressed some of the concerns raised at the 2005 Consensus Conference. This finalized an earlier draft guidance published in 2006. This document is not law, but provides “the Agency’s current thinking” on the topic. The guidance document states that the FDA and DHHS regulations do not preempt state laws, and accordingly state law could preclude approval of research without consent even though the protocol meets the requirement of the federal regulations. As to the requirement of the “prospect of direct benefit,” the guidance notes that “information from animal and preclinical studies, other clinical data . . . or other evidence should support the potential for the investigational product to provide a direct benefit to the individual subjects.”

With respect to the requirement that the IRB find that “available treatments are unproven or unsatisfactory,” the guidance clarifies that “unproven” means that “there is not substantial evidence that the treatment is effective for the condition of interest.” “Unsatisfactory” refers to situations where there is an approved treatment, but the treatment is unsatisfactory due to “safety” or “efficacy” issues. With respect to the requirement that the IRB find that a study “could not practicably be carried out without the waiver from informed consent,” the guidance states that the waiver should not be available where results from trials with consenting subjects could be generalized to non-consenting subjects, or where research “would not be unduly delayed” by using consenting subjects. The guidance also notes that there may be emergency situations where an individual is conscious and able to communicate and indicates that he or she does not want to participate in the emergency research study, some other evidence (e.g., medical jewelry or a wallet card) indicates that the individual would not want to participate, or an LAR or family member who is present indicates the individual does not want to participate. In such cases, the refusal to participate should be honored.

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189. See Guidance, supra note 180.
190. Id. at 1.
191. Id. at 4.
192. Id. at 8.
193. Id. at 10.
194. Id. at 11.
Under the guidance, the IRB is required to review the plans for “community consultation” and “public disclosure” before approving the protocol. Community consultation activities are supposed to ensure that the communities where the research is conducted and the potential subjects are provided adequate information about the risks and benefits of the research and have an opportunity to ask questions about the research and express their views on it prior to IRB approval. The guidance provides some additional information on the FDA’s expectations with respect to the goals of “community consultation,” i.e. 1) showing respect for persons by informing the community in advance about the study; 2) providing an opportunity for “meaningful input” from community members prior to approval of the study; 3) showing respect for community members by allowing its representatives “to identify potential community-level concerns and effects of the research;” and 4) showing respect for the autonomy of the subjects.

The guidance defines “the community in which the research will be conducted” as “the geographic area where the hospital or clinical investigator site is located.” And “the community from which the subjects will be drawn” is defined as “the group of patients who share a particular medical or characteristic that increases the likelihood that they (or a family member) may be enrolled in the study.” The guidance specifically notes:

Community Consultation is not the same as community consent. Community consent is the idea that a community’s leaders can consent to the community’s participation in a study, and thereby eliminate the need for researchers to obtain informed consent from individual subjects. Community consent is not a substitute for individual informed consent . . . nor can the community consent on behalf of individual members to permit their participation in a study. The usual way of respecting a person’s autonomy—by directly obtaining the individual’s consent—may be impossible for emergency research.

196. Id. 18.
197. Id. at 16.
198. Id. at 25.
199. Id.
200. Id.
Similarly, community consultation cannot substitute for individual consent, although community consultation does represent an opportunity for people situated similarly to potential study subjects to hear about the study and express views about it.\(^{201}\)

During community consultation, sponsors and investigators are supposed to inform the relevant communities that informed consent will not be obtained from the research subjects and explain why not.\(^{202}\) All “relevant aspects” of the study are to be explained including the protocol design, its risks and benefits, and why current treatments are unproven or unsatisfactory.\(^{203}\) Sponsors and investigators are also supposed to get feedback from the communities on the proposed research.\(^{204}\)

As to why community consultation is important the guidance notes that it “provides an opportunity for communit[ies] to understand the proposed clinical investigation and its risks and expected benefits, and to discuss the investigation.”\(^{205}\) It is also designed to “strengthen community confidence in the role of the IRB and its decision-making capacity.”\(^{206}\)

It is contemplated that the sponsor will pay the costs of the community consultation activities.\(^{207}\) The IRB is supposed to review the research protocol and the plans for community consultation as a package.\(^{208}\) Although the sponsor is required to provide the IRB plans for community consultation and public disclosure prior to the start of the study,\(^{209}\) the preferred approach now is for researchers, ethicists, and members of the IRB to work collaboratively to develop the community consultation process.\(^{210}\)

There are a variety of methods that can be used for community consultations, e.g., town hall meetings, focus groups.

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202. Id. at 26.
203. Id.
204. Id.
205. Id. at 27.
206. Id. at 28.
207. Guidance, supra note 180, at 28.
208. Id.
209. Id. at 17.
random-digit-dialing, or a combination of these methods, but they all have shortcomings. Due to poor and biased attendance, the town hall approach may be the least effective, and it takes substantial effort and expense to make it worthwhile. The feedback from the specific focus group may not reflect the attitudes of the wider community. And while random-digit-dialing is possibly most inclusive and less prone to bias, it provides no direct interaction with investigators.

The extent of community consultation is left to the discretion of the IRB. The IRB may conduct the community consultation activities itself, and even if the sponsors conduct them, the FDA recommends that IRB members attend the community consultation activities. The IRB is supposed to consider any concerns or objections raised during the community consultation activities. The regulation does not require that an “opt-out” mechanism be provided for community members who do not want to participate in the subject. But the IRB can require that an opt-out mechanism be provided. Opt-out mechanisms can include a medical bracelet or card to be carried in a wallet. If an opt-out mechanism is used, then members of the community should be made aware of them through the community consultation activities and public disclosure.

IV. THE ARGUMENTS MADE AGAINST THE ERWC RULE

There are essentially four arguments that have been made against the ERWC rule: A) informed consent is an absolute requirement; B) many patients would not want to participate in research trials without being consulted; C) the use of community consultation is not an adequate substitute for informed consent; and D) it does not adequately protect patients.

211. Id.
212. Id.
213. Id.
214. Id.
216. Id. at 17.
217. Id. at 18.
218. Id. at 30.
219. Id.
220. Id.
222. Fost, supra note 160, at 173.
A. INFORMED CONSENT IS AN ABSOLUTE REQUIREMENT

Although patient autonomy is generally acknowledged to be the trump value in the treatment context, in clinical research it is in constant tension with the desire to benefit society. Unfortunately, as noted supra, there have been many examples in history where abandonment of the informed consent requirement has led to horrific consequences for the subjects. And notwithstanding its potential benefit to society, participation in emergency medical treatment research entails risks that could have a dramatic and lasting impact on the individual. Not all experimental emergency medical treatment measures are successful, and the research subject could die or be left with severe disabilities due to inclusion in the trial. Individuals who are suffering life-threatening medical conditions, or who have been incapacitated by severe physiologic stress or derangement should be considered vulnerable and incapable of consenting.

It could be argued that when an individual is in extremis (such as a cardiac arrest, or when unconscious), they would give implied consent to any standard emergency treatment. This is true, and is a basic norm of ethics in emergency medicine in the treatment context as currently taught and practiced in the United States. Without explicit information to the contrary (such as a conversation with the patient or family, or a written document such as a “living will”), it is presumed that all individuals would want physicians to attempt to preserve their lives. But using this same line of reasoning to justify ERWC fails to recognize the basic difference between accepted standards of care for the benefit of the individual undergoing treatment and experimental or research activities carried out on a patient primarily for the benefit of others. While implied consent is the norm in the treatment situation (e.g., use of generally accepted medical actions for resuscitation), it should not be the norm for research activity, precisely because of the need to respect and protect research subjects as much as possible from experimental treatments that may not benefit them.

It is generally assumed that the informed consent process should be more rigorous in the research context than in the treatment context. There are several reasons for this. First, the risks of the

224. Carnahan, supra note 52, at 575.
innovative treatment may not be well known. Second, research is not conducted primarily for the benefit of the research subjects and participation in the trial may not benefit the subject. Third, research subjects may be operating under a "therapeutic misconception," i.e. they may have an unrealistic belief that they will benefit from participation in the research study. Fourth, while in the treatment context it may be assumed that the physician acts primarily for the benefit of the patient, this is not the case in the research context where there are "conflicting interests." The motives of the researcher may include not only the desire to benefit society and contribute to knowledge, but also to derive potential financial benefit and enhance one's professional reputation.

Jay Katz, one of the leading proponents of informed consent, characterized the ERWC rule as an unfortunate abandonment of the first principle of the Nuremberg Code. He also believed that it sent a "dangerous message" to researchers that proceeding with their research was more important than obtaining consent for subjects. Katz also criticized the ERWC rule for its obfuscation of the research/therapy distinction and the vast and vaguely defined discretion granted to IRBs in administering these fateful regulations. He further noted:

If the FDA is serious that the waiver of informed consent is a "serious matter," then the agency should rescind the regulations and draft new ones that are narrower in scope and more explicit about the

225. Id.
226. Id.
228. Carnahan, supra note 52, at 575. As Jay Katz has noted in the research context, "[I]ndividual patient-centered therapy gives way to a collective patient-centered endeavor in which the abstraction of the research question tends to objectify the person-patient." Katz, supra note 145, at 15–16.
229. Jesse A. Goldner, Dealing with Conflicts of Interest in Biomedical Research: IRB Oversight as the Next Best Solution to the Abolitionist, 28 J. L. MED. & ETHICS 379 (2000).
231. Id.
permissible limits of nontherapeutic research in emergency care research. As currently drafted, they represent a triumph of the pharmaceutical industry, medical device companies, and the research community—over the therapeutic interests of patient-subjects as well as society’s interests in limiting the authority of the state and the investigators to conscript subjects for research without their consent.233

On the other hand, Norman Fost argued that “[c]ontrary to the first principle of the Nuremberg Code, the voluntary consent of the human subject is neither necessary nor sufficient for ethically and legally responsible research in the United States.”234 He contended that consent is “primarily...a way of allowing patient autonomy to express itself” and that “it is certainly not an absolute.”235 Baruch Brody viewed the ERWC rule “as a mature recognition of the existence of multiple values surrounding the research effort,” but also acknowledged that it is “wrong” to use people without their consent or the consent of their proxy for risky research. He further argued that the regulations “only make sense when you stop seeing the moral world as governed by these types of absolute values.”236

B. MANY PATIENTS WOULD NOT WANT TO PARTICIPATE IN RESEARCH TRIALS WITHOUT BEING CONSULTED

It could be argued that subjects may want to participate in trials under the ERWC rule in order to gain access to innovative treatments otherwise unavailable, and thus would consent if they could. Fost argues that since there is a greater likelihood that emergency/critical care patients will be exposed to “innovative treatment,” patients participating in a clinical trial of emergency medical treatment may actually be provided more protection than patients receiving innovative treatments that are not participants in a clinical trial.237 On the other hand, George Annas argues that randomization is still problematic: “Most people would not want a doctor to flip a coin when they come into an emergency room...
[T]hey would want their doctor to do what is best for them...[T]hat is what you lose in this—you lose the right to have your doctor treat you however he thinks best." 238 And he further states: "For most people, research is not an opportunity... The average person wants treatment, not an opportunity to be researched on... [T]he idea that people might be denied new treatments is silly... If we knew it would work, it would be a treatment." 239 But Fost, relying on results from the use of deferred consent in a 1990 randomized placebo trial involving the use of calcium channel blockers in comatose survivors of cardiac arrest, argues that most patients and families would prefer the opportunity to receive experimental treatment where the standard treatment is associated with poor outcomes. 240

At this time, it is unclear whether the ERWC rule is acceptable to the public. 241 Indeed, there appears to be some dissonance between the approach taken by the ERWC rule and public attitudes. In a survey of patients in an emergency department, Wilets et al. (2003) found a significant level of mistrust of researchers with 49 percent of the respondents equating research subjects with "human guinea pigs." 242 In a survey of patients in the emergency department of a tertiary care center conducted prior to the implementation of the rules authorizing waiver of informed consent in emergency treatment research, Smithline & Gerstle (1998) found that 73 percent of those surveyed approved of research without consent where the absolute risks of the research were minimal, but only 50 percent if the absolute risks were more than minimal and outweighed by the potential benefits. 243

Abboud et al. (2006) surveyed adult patients in an urban emergency department (ED) and a geriatric clinic (GC) about their willingness to participate in a research involving treatments for cardiopulmonary arrest. Those surveyed were asked to imagine that they had been brought to the emergency room for cardiopulmonary arrest and that their chance of survival was less than 1 percent. They found that 30 percent (ED) to 50 percent (GC) of those surveyed

239. Id.
240. Fost, supra note 160, at 179.
would not want to participate in a randomized clinical trial of a new drug that involved a waiver of consent. On this basis, they concluded "that a consistently high level of altruism cannot be assumed." Longfield et al. (2008) found that while 82 percent of attendees at community consultation meetings for the PolyHeme study approved of its conduct in their community, 35 percent of persons objected to enrollment in the study without prior consent. Richardson et al. (2005) conducted focus groups for residents of buildings in New York City where the PAD trial was ongoing finding that while there was "significant" support for research without consent, there was also some adamant opposition to it. On the other hand, Dix et al. (2004) found that all of the 137 attendees at seven community consultation sessions approved of research without consent for a study of brain trauma patients brought to an emergency room.

Dula (1997) has argued that the ERWC rule is particularly problematic in the African-American community. She notes that African-Americans will be disproportionately subjected to the waiver of informed consent because a large number of trauma centers are located in University-affiliated public hospitals serving inner cities. And they suffer a disproportionate number of firearm related traumatic injuries. She then notes:

[Implementation of the new regulations will be difficult in minority populations because of the history of abuse of informed consent. African Americans have historically been subjects of medical experiments without consent, without benefit to themselves, and often without benefit to science. Many will wonder what's different about this latest abrogation of

245. Id. at 471.
informed consent. Is this yet another opportunity to force African Americans to be guinea pigs for “white” science?250

In the preamble to the proposed ERWC rule, the FDA argued that it would be likely to increase the enrollment of minority and low income patients in critical care studies. But as Saver notes, the FDA failed to acknowledge that “[m]any African-Americans. . .are suspicious of enrolling in clinical trials because of the historic and disproportionate abuse of black patients in the name of medical research, often without their consent.”251 Saver further argues that simply waiving consent does not adequately address the attitudes in the African-American community, and does not sufficiently respect the autonomy of members of that community.252 In a study of the implementation of the public disclosure requirement of the ERWC rule, Shah and Sugarman (2003) found that community members expressed concerns about racial bias in almost one-third of the documented two-way communications (e.g., open public meetings, meetings with specific groups in the community, telephone poll, talk-radio program with call in).253

C. COMMUNITY CONSULTATION IS NOT AN ADEQUATE SUBSTITUTE FOR INFORMED CONSENT

Although community consultation is not equivalent to community consent,254 it plays a significant role in justifying the waiver of informed consent.255 Richardson (2006) argues that “community consultation serves several important ethical purposes particularly in the absence of informed consent,” e.g., promotion of “trust among community members;” encouragement of “trustworthy behavior by researchers;” revelation of additional risks to subjects;

250. Id.
252. Id. at 254.
254. Biros, supra note 5, at 558.
255. Lynne D. Richardson et al., The Role of Community Consultation in the Ethical Conduct of Research Without Consent, 6 AM. J. OF BIOETHICS 33 (May/June 2006).
and suggestions for improvement of the protocol.\textsuperscript{256} A 2002 report by the Institute of Medicine (IOM) assessing the system for protecting research subjects noted:

The notion of community consultation increasingly is viewed as beneficial to participants, to investigators, and to the integrity of the study design . . . . It is especially critical when the investigator is not a member of, or is unfamiliar with, the community that is the focus of or the host for the research. However, the idea of "community consent" has been problematic for several reasons, but largely because of the difficulty involved in defining communities. Communities are defined by social and ethnic group boundaries, which are highly permeable and fluid. Individuals rarely reside fully in one group over time and place and often belong to more than one community. In addition, communities are more often socially rather than biologically constructed, and individuals self-define their communities.\textsuperscript{257}

The IOM report further noted the difficulty of "identifying the spokesperson(s) for a particular community or ethnic group for the purpose of obtaining a community or group's consent."\textsuperscript{258} It also recommended steps to strengthen the community consultation process, including requiring researchers "in their grant proposals, to justify their selection and definition of communities; to demonstrate sensitivity to the possible community implications of their research where appropriate; and to anticipate potential group harms."\textsuperscript{259}

Community consultation is insufficient for several reasons. First, within a single community, there is a diversity of viewpoints and perceptions as to the validity and necessity of the proposed research. It is unclear how such community disparities are to be

\textsuperscript{256} \textit{Id.} at 33.
\textsuperscript{258} \textit{Id.} at 127–28.
\textsuperscript{259} \textit{Id.} at 128.
addressed by the governing IRBs. Further, there is no basis for assuming that the individual upon whom the research is conducted shares the viewpoint of those who approve research under such circumstances.

Second, the individual selected as a subject for the research may not actually be a member of the community that was consulted about the appropriateness of the research protocol. Approval of the protocol is based on consultation with members of the particular geographic community. If the community raises significant objections to the protocol during the consultation phase, then investigators may decide not to pursue that place as a site for research, or the local IRB may refuse to approve the protocol. But travelers, visitors, or individuals passing through a particular locality where an emergency medical treatment protocol has been approved, and who may have never heard of the research activity, could be placed into the research protocol simply by the fact of their presence in the community at the time they experience a medical emergency regardless of the lack of informed consent or any involvement by their home community in approval of the protocol.

Third, community consultation is not the equivalent of valid proxy/surrogate consent. Typically, proxy/surrogate consent requires that another individual, usually (but not necessarily) related to the research subject, make an informed decision on behalf of the incapacitated subject. This individual is one who should have some knowledge of the subject’s wishes and desires and generally is able to understand and respect the faith perspective of the subject. Sometimes the surrogate/proxy is designated in advance by the subject. Usually, the surrogate/proxy is supposed to apply a substituted judgment standard, i.e., to do what the subject would do if the subject had decision-making capacity. When that evidence is lacking, then the proxy is supposed to decide in accordance with the best interests of the subject. On the other hand, approval of research without consent presumes that if they could, individuals enrolled in the trial would give permission to participate, but this may not be the case. Community preferences as revealed during community consultation may be in direct opposition to an individual’s deeply

260. Richardson et al., supra note 255; see also Michelle Biros et al., Community Attitudes Towards Emergency Research and Exception from Informed Consent, 80 RESUSCITATION 1382 (2009).

261. Biros, supra note 260, at 1385.
held beliefs. Thus the subject’s beliefs are not treated as having any value unless they happen to coincide with what the community deems to be appropriate for its own good.

Richardson (2005) notes that “there is no consensus regarding the definition of ‘community’ or appropriate methods of consultation or notification regarding research without consent.”262 Some have questioned the efficacy of current methods used in community consultation.263 Holloway (2006) particularly questioned its efficacy in the African-American community noting: “Community consultation is a performative process that takes on the character and conduct of proxy without its authority.”264 Holloway focused on the PolyHeme study that was conducted at Duke University. This multi-site Phase III RCT involved the use of a blood substitute in 720 trauma patients at Level I victims both at the scene of an accident and for twelve hours after reaching the hospital even though whole blood was available in the hospital setting. Holloway notes that Duke’s attempts at community consultation involved four (reportedly poorly attended) information sessions, a slot on a Rotary Club’s meeting agenda, two sessions at a mall, and a session at a Fourth of July baseball game, while requests to speak to two black churches were rebuffed.265 Dula (1997) also noted that it is more difficult to implement the community consultation requirement in African-American communities.266 Due to the legacy of mistrust, she believes that investigators “will have difficulty in gaining entry to minority communities.” And she argues it will particularly be difficult to make contact with drug dealers and gang members, the most likely participants in the research trial.267

On the other hand, Dickert & Sugarman (2006) argue that if its goals and methods are properly understood, community consultation can play an important role in identifying the issues raised by Holloway.268 They acknowledge that community

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262. Richardson et al., supra note 255, at 1089.
263. See, e.g., Karla F.C. Holloway, Accidental Communities: Race, Emergency Medicine, and the Problem of PolyHeme, 6 AM. J. OF BIOETHICS 7 (May/June 2006); Nicole Delorio & Katie McClure, Does Emergency Exception from Informed Consent Process Protect Research Subjects?, 12 ACAD. EMERGENCY MED. 1056 (Nov. 2005); Terri Schmidt et al., The Meaning of Community Consultation, 6 AM. J. OF BIOETHICS 30 (May/June 2006).
265. Id.
266. Dula, supra note 249.
267. Id.
268. Neal W. Dickert & Phoebe R. Berman, Community Consultation: Not the Problem—An
consultation is not the equivalent of community consent and “should not be seen to be a proxy for consent.” They posit that the ethical goals of community consultation are: “1) enhanced protection; 2) enhanced benefits; 3) legitimacy; and 4) shared responsibility.” They concede, however, that “how to perform community consultation well is poorly understood” and that more studies are needed on “how different methods of consultation advance the goals that community consultation is designed to receive.”

While it is generally acknowledged that community consultation is the most difficult aspect of obtaining a waiver of informed consent, research on its effectiveness is somewhat limited. McClure et al. (2003) surveyed patients, family members and visitors in the waiting rooms of emergency departments at two academic medical centers concerning their attitudes on the waiver of informed consent in emergency medical research and the community consultation process. Both centers were sites for the Public Access to Defibrillation Study (PAD) in which a waiver of informed consent had been approved. 88 percent of those responding to the surveyor’s questions agreed with the general statement that informed consent of the subject should be required before enrollment in a research study. 34 percent agreed that enrolling subjects without informed consent was acceptable in a research situation. 70 percent indicated their willingness to participate in an emergency treatment study without informed consent “if it were important to learn about the treatment for a condition that currently has no good treatment.” As to community consultation, 73 percent disagreed with the statement that informing the community before doing a study without consent is not necessary. 45 percent believed that using community consultation as a substitute for informed consent was reasonable, and 50 percent indicated they would attend a community consultation meeting, yet only 5 percent knew of the ongoing PAD trial.

Important Part of the Solution, 6 AM. J. OF BIOETHICS 26 (May/June 2006).

269. Id.
270. Id.
271. Id. at 27.
274. Id. at 355.
275. Id.
Triner et al. (2007) surveyed emergency department patients in an urban academic medical center concerning their awareness of the ongoing PolyHeme trial being conducted in the community. The survey was taken after community consultation and public notification. Only 8 percent of those surveyed were aware of the trial and only 4 percent were aware of specific risks. They also found that the population of potential enrollees did not indicate a high degree of acceptance of these enrollment practices.

Nelson et al. (2008) studied the efficacy of methods (community meetings, random-access dialing, and website) used for community consultation in the ROC hypertonic saline trial. The community meeting consisted of both open forums that were advertised in local media, and presentations to organized community groups. After these meetings, attendees filled out a paper survey. In the random-access survey, callers were provided with a standardized script and survey questions. Finally, a website was designed with information about the study and a link to a survey. They found that open forum meetings, the most frequently used method of community consultation, “may be an ineffective [means of consultation] because of both poor attendance and high rates of agreement with the proposed study.”

D. THE ERWC RULE DOES NOT PROVIDE ADEQUATE PROTECTION FOR PATIENTS

Due to the dearth of published studies and appropriate outcome measures, it is unclear whether the ERWC rule provides adequate protection for research subjects. There are additional concerns where one arm of the trial will be deprived of the standard treatment. One of the prerequisites to approval of a trial under the ERWC rule is that the IRB find that “available treatments are unproven or unsatisfactory.” And as noted supra, the 2011 guidance permits trials where “there is not substantial evidence that the

278. Id. at 418.
279. Id. at 418–19.
280. Id. at 423.
treatment is effective for the condition of interest,” or where there is
an approved treatment, but it is unsatisfactory due to “safety” or
“efficacy” issues.

Richard Saver argues that the ERWC rule as initially
proposed had embraced “too lax a standard of ‘clinical equipoise’ for
guiding IRBs in determining whether the risks of the experiment and
the state of medical uncertainty warrant waiver of consent.”282 He
particularly criticizes the definition of clinical equipoise set forth in
the preamble to the proposed rule, i.e., “clinical equipoise would
exist whenever at least a reasonable minority of medical
professionals believe the experimental treatment would be as good as,
or better than, the standard treatment.”283 This definition of clinical
equipoise was reaffirmed in the preamble to the final rule where it
was stated: “The agency thinks that this description provides
sufficient guidance to IRBs and that it is appropriate to allow IRBs to
determine when clinical equipoise exists.”284

In his criticism, Saver argues that the FDA should embrace
the standard for clinical equipoise proposed by Benjamin Freedman,
i.e., “a sufficient state of medical uncertainty should exist within the
clinical community and the research itself should be designed so that
the experiment itself will make a difference in resolving the medical
issues” (emphasis in original).”285 He contends that trial must be
designed so that it will provide “generalizable, acceptable
answers.”286 Thus, he argues for special scrutiny of the soundness of
the research proposal noting that the failure to ensure that the trial is
well designed is particularly problematic where consent is waived.287
The preamble to the final EWRC rule states that “. . .an IRB should
not approve a clinical investigation that is poorly designed and, thus,
unable to answer the scientific question posed,”288 but it does not
provide any additional guidance to IRBs concerning study design.

Saver also argues that the rule as originally proposed did not
provide adequate guidance to IRBs in determining whether the
risk/benefit calculus of the protocol was acceptable. He argues that

282. Saver, supra note 251, at 268.
283. Id. at 255 (citing 60 Fed. Reg. 49086, at 49095 (Sept. 21, 1995)).
285. Saver, supra note 251, at 256 (citing Benjamin Freedman, Equipoise and the Ethics of
Clinical Research, 31 New Eng. J. Med. 141, 144 (1987)).
286. Id. at 258
287. Id.
there should be a mechanism in place to ensure that the experimental therapy provided under the protocol would be equal to or better than the standard treatment.\textsuperscript{289} The proposed rule merely required that the “risk of the investigation is reasonable in light of what is known about the medical condition and the risks and benefits of current therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.”\textsuperscript{290} The final EWRC rule provides an additional requirement: the IRB must document that “appropriate animal and other preclinical studies have been conducted, and the information derived from those studies and related evidence support the potential for the intervention to provide a direct benefit to the subjects.”\textsuperscript{291}

Notwithstanding these safeguards, the ERWC Rule opens the door to studies like the PolyHeme Study, discussed \textit{supra}, where patients are deprived of standard treatment without their consent. Similarly, the ROC CCC study, discussed \textit{supra}, also involves depriving patients of the standard AHA approved treatment, i.e., CPR with intermittent ventilation. In both studies, it was contended that there is clinical equipoise because the standard treatments were unsatisfactory or unproven and the experimental intervention may be as good or better based on prior studies. If studies are to be approved on this basis under the ERWC rule, then it is important that IRBs carefully scrutinize these claims.

Katz was particularly concerned about placebo trials.\textsuperscript{292} Certainly, under the principle of clinical equipoise, it is more difficult to justify depriving patients in one arm of the trial of the standard treatment. Fost argues that placebo trials could be justified where both groups are provided with the standard treatment and only one group is provided with an additional experimental treatment. He contends that most people would not object to participation in this type of placebo trial.\textsuperscript{293} But the regulations leave the door open to placebo trials where standard treatment is not provided.\textsuperscript{294} Katz notes:

\begin{quote}
The FDA tried to reassure critics that “[i]n virtually all cases, when a placebo is used, standard care, if any,
\end{quote}
would be given to all subjects, with subjects randomized to receive, in addition, the test treatment or a placebo" . . . Why not in all cases? The FDA discusses only one exception, "the situation in which the test is to determine whether standard treatment is in fact useful. In that case, there must be a group that does not receive it" . . . Is this the only exception? And on what criteria is "not useful" based? And why should not in these situations standard treatment be compared with promising experimental treatments? Is the exception introduced in order to justify the fateful, unelaborated, and apodictic next sentence: "The agency believes that it is important to recognize in the regulation, that placebo-controlled trials may be conducted under this emergency research provision; thus it is retaining the wording of this section" . . . Why?295

The 2011 guidance states that "in virtually all cases when a placebo is used, standard care (if any) would be given to all subjects, with subjects randomized additionally to receive either a test treatment or a placebo."296 But it also notes an exception to this requirement where "the study objective is to determine whether some aspect of the standard treatment is in fact useful."297 The guidance continues:

Sponsors designing trials that include subjects who neither receive some aspect of the standard treatment nor a test article should provide a sound rationale for this type of study design. Choosing an appropriate design for these studies may be particularly challenging. FDA recommends that sponsors consult with the appropriate FDA office or division about the proposed study design.298

295. Id.
297. Id.
298. Id.
V. POTENTIAL CONFLICT WITH CATHOLIC TEACHING

Generally, the principles in the Nuremberg Code, the Declaration of Helsinki, and the Belmont Report are consistent with "Catholic teaching on the natural law and the intrinsic dignity of the human person." But there is some discordance in these documents on the propriety of research without consent. While under the Nuremberg Code research without consent is illicit, it may be permissible under the current version of the Declaration of Helsinki which provides:

Research on individuals from whom it is not possible to obtain consent, including proxy or advance consent, should be done only if the physical/mental condition that prevents obtaining informed consent is a necessary characteristic of the research population. The specific reasons for involving research subjects with a condition that renders them unable to give informed consent should be stated in the experimental protocol for consideration and approval of the review committee. The protocol should state that consent to remain in the research should be obtained as soon as possible from the individual or a legally authorized surrogate.

In addition, research without consent may be justifiable under the principles set forth in the Belmont Report. While circumventing the principle of respect for persons, research without consent may be consistent with the principles of beneficence and justice. Under the principle of beneficence, research may be justified by benefits that flow from developing more effective treatments for emergency medical conditions. There is also the prospect of direct benefit for the subjects, but the difficulty is in determining whether the risks outweigh the benefits. Justification under the principle of justice is more problematic. While arguably emergency research conducted in trauma centers may have more impact on economically and

299. See generally A CATHOLIC GUIDE TO ETHICAL CLINICAL RESEARCH 6 (2008).
300. DECLARATION OF HELSINKI, supra note 69, at ¶ 17.
301. BELMONT REPORT, supra note 122, at B.2.
educationally disadvantaged populations, it may also provide those populations with access to more effective treatment.\textsuperscript{302}

In the research context, Catholic teaching seems more in accord with the absolutist position of the Nuremberg Code than with the approach taken by Fost, discussed supra. As Beecher noted in his landmark article, "[A]ccording to Pope Pius XI . . . science is not the highest value to which all other orders of values . . . should be subordinated."\textsuperscript{303} Similarly, the guidelines for clinical research adopted by the Catholic Medical Association and the National Catholic Bioethics Center (the Catholic Guidelines) note: "The subject and not a procedure, process, or product being studied is the most important aspect of every clinical trial."\textsuperscript{304}

The Catechism of the Catholic Church provides: "Experimentation on human beings does not conform to the dignity of the person if it takes place without the informed consent of the subject or those who legitimately speak for him."\textsuperscript{305} Thus under the Catechism, "experimentation that takes place without the subject’s informed consent is per se a violation of human dignity."\textsuperscript{306} The Catholic Guidelines developed by the National Catholic Bioethics Center and the Catholic Medical Association state: "Potential subjects who do not understand the nature of the study, or who otherwise lack capacity, cannot provide informed consent."\textsuperscript{307}

In \textit{Evangelium Vitae}, Pope John Paul II repeatedly and forcefully teaches the value and dignity of human life and the need to be vigilant in protecting life, particularly when it is most vulnerable.\textsuperscript{308} \textit{The Ethical and Religious Directives for Catholic Health Care Services} clearly articulates the importance of protecting vulnerable patients.\textsuperscript{309} The Catholic Guidelines provide, "[i]ndividuals who are vulnerable by virtue of . . . medical or psychological condition, or cognitive status must be particularly protected by all physicians and medical researchers."\textsuperscript{310} Unconscious

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\bibitem{302} \textit{BELMONT REPORT}, \textit{supra} note 122, at B.2.
\bibitem{303} Beecher, \textit{supra} note 87, at 1354.
\bibitem{304} \textit{A CATHOLIC GUIDE TO ETHICAL CLINICAL RESEARCH} 9 (2008).
\bibitem{305} \textit{CATECHISM OF THE CATHOLIC CHURCH}, ¶ 2295, \textit{available at} http://www.vatican.va/archive/ENG0015/__INDEX.HTM.
\bibitem{306} Garnett, \textit{supra} note 65, at 503, n. 258.
\bibitem{307} \textit{CATHOLIC GUIDE}, \textit{supra} note 304, at 7.
\bibitem{308} \textit{POPE JOHN PAUL II, EVANGELIUM VITAE} (Mar. 25, 1995), n. 44.
\bibitem{309} \textit{ETHICAL AND RELIGIOUS DIRECTIVES FOR CATHOLIC HEALTH CARE SERVICES [ERDs]}, Dirs. 25, 26, 27, 28, and 31 (5th Ed. 2009).
\bibitem{310} \textit{CATHOLIC GUIDE}, \textit{supra} note 304, at 8.
\end{thebibliography}
persons are considered to be particularly vulnerable under the Catholic Guidelines, and while they may be included in clinical research that provides direct benefits, "great care must be exercised to protect their well-being and enhance their safety." Moreover, "disadvantaged subjects should never be enrolled in clinical trials from which they cannot benefit at least indirectly." Individuals who are experiencing life-threatening medical conditions or sudden deterioration of physiologic function due to illness or injury are particularly vulnerable. This is the exact target population of the ERWC rule; thus it could be argued that enrolling such patients in a study without their consent based on the mere fact of geography (illness or injury occurring in a particular research community) violates the basic ethical norm of respect for the human person. The Catholic Guidelines also require that "research...be conducted according to accepted scientific principles." It must be "necessary and potentially useful." It is not acceptable to enroll subject in trials that have "unnecessary or disproportionate risks which overshadow the expected benefit." Thus, it is particularly important to protect patients in trials where they are deprived of a standard treatment.

Waiving informed consent also undermines the altruistic motive for participation in research by depriving subjects of an opportunity to agree to participate in a research protocol that may not confer any direct benefit on them in order to benefit the community. In arguing that physicians ought to ask their patients to participate in therapeutic experiments, Dr. Edmund Pellegrino notes that, "not to ask is to deprive the subject of an opportunity for altruism that she may cherish." A subject who consents to participate in a medical research study involving risks to health may be willing to do that in order to benefit society or others. In light of the voluntary nature of the undertaking, the subject participating in the research may derive a psychological benefit, but there is no such benefit to the patient that is enrolled in a study without his or her actual consent.

Moreover, the acceptance of waiver of consent in emergency research could lead to attempts to adopt norms favoring waiver of consent in other contexts. For example, although the concept of

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311. Id. at 9, n. 20.
312. Id. at 11.
313. Id.
314. Id.
presumed consent for the removal of organs after death for transplantation is not new, there has been a revival of this idea and a push to move toward legislation mandating that unless otherwise indicated, all individuals would be presumed to have given permission for removal of organs after death for transplantation. This is in direct violation of the moral norms set forth by the Catholic Church and the teaching of Pope John Paul II. Current proposed legislation in the State of New York indicates how far along this path we have begun to travel.

The reliance on community consultation as a justification for waiving consent is troubling from a Catholic perspective insofar as it makes the will of this nebulous community binding on all members of the community. This sets the preferences of the community as the moral standard, and gives the power to authorize research on individuals to an anonymous group rather than one’s loved ones or chosen surrogates. It can readily be seen that approval by such communities could be utilized to justify other types of actions, both medical and non-medical, which would negate or undermine the basic rights of the individual. For example, Donum Vitae specifically speaks about such coercive force of the community in addressing the issue of use of human embryos or fetuses for experimentation.

VI. CONCLUSION

The ERWC rule violates the first principle of the Nuremberg Code by permitting researchers to enroll subjects into trials without

318. CATECHISM OF THE CATHOLIC CHURCH, supra note 305, at ¶ 2296 (“Organ transplants are in conformity with the moral law if the physical and psychological dangers and risks to the donor are proportionate to the good sought for the recipient. Organ donation after death is a noble and meritorious act and is to be encouraged as an expression of generous solidarity. It is not morally acceptable if the donor or his proxy has not given explicit consent.”).
their consent or the consent of a proxy. Also, Catholic teaching appears to be consistent with the Nuremberg Code. The ERWC rule may also conflict with Catholic teaching because community consultation is not an acceptable substitute for informed consent, and may not provide adequate protections for patients. Accordingly, we believe that IRBs affiliated with Catholic institutions should carefully scrutinize trials proposed under the ERWC rule. These trials are particularly troubling where they involve the denial of standard treatment to some subjects.