FEATURE ARTICLE

The ERDs and Clinical Research: Some Thoughts and Experiences from Georgetown University Medical Center

Kevin Fitzgerald, SJ, Ph.D.
David Lauler Chair
Georgetown University Medical Center
Washington, DC
ktf3@georgetown.edu

The Catholic Health Association proudly proclaims its rootedness in the long and impressive history of Catholic health care, especially the focus on bringing excellent health care to those most in need. In order to continue to promote this tradition, it is crucial that Catholic health care institutions participate in and significantly contribute to clinical research that will generate improved and new treatment options for the full spectrum of illness and disease. Part of the contribution that Catholic institutions can bring to the clinical research arena is the robust framework of values, rigorously developed over two thousand years, which has undergirded the extensive health care effort the Church has always pursued as mandated by the words and actions of Jesus Christ. These values include the clear recognition of the ultimate worth of each and every human being, and, hence, our duty as those called by Jesus, to care for any and all in need—in particular medical need.

Whatever medical care we provide, it is always to be given in a manner that respects and supports the dignity of each patient, no matter their circumstances or prognosis. This approach to health care has important and substantive contributions for both the goals and procedures of clinical research. Since human beings are involved in clinical research, research protocols should be structured so as to focus on the benefits the research can provide for all research participants and the future patients whose treatment the research is intended to improve.

These benefits extend from the care and gratitude terminally ill participants who altruistically volunteer for research projects can receive from the clinical research staff, who value the selfless contributions of these research subjects, to the concern research designers, staff and reviewers infuse into their efforts to ensure that a given research project generate results that will provide the benefits research participants and future patients desire. While many, if not almost all, involved in clinical research would embrace these goals, Catholic institutions can add their traditional dedication to, and focus on, human dignity to help make sure that these goals are given the highest priority.

In addition to these broadly accepted goals and procedures regarding clinical research, the Catholic health care framework also brings requirements that are not as broadly embraced within the clinical research arena, and, in fact, are sometimes seen as being in conflict with current Federal requirements. For instance, when clinical trials involve the use of drugs that can be harmful to a developing embryo or fetus, FDA and/or DHHS mandates usually require the research participant to agree to avoid pregnancy by using two methods of birth control, including one barrier method. This requirement conflicts with the *Ethical and Religious Directives* (ERDs) which all Catholic health care institutions have as their fundamental moral guideline for the pursuit of ethical medical practices and research.

Does this clear conflict between the Federal requirements and the ERDs mean that Catholic health care institutions must avoid participating in any research protocols that have this requirement? Must Catholic health care simply abandon its involvement in such crucial research because governmental requirements are structured in a way that does not take Catholic medical moral principles into consideration, or can Catholic health care institutions use their rich moral tradition to propose alternative approaches to the requirements of clinical research that actually improve the experience of the research participants and the potential outcomes of the research? While the latter option may not be achievable always, it certainly is better aligned with the traditional goals of Catholic health care, and, one can argue, is better for clinical research overall.

This approach of employing the insights and perspectives of Catholic health care to engage and improve current clinical research is actually very much in tune with the recent, increasing awareness of the need for greater public involvement in the clinical research enterprise. This awareness is incorporated into the expanding engagement of the public through the practice of Community Based Participatory Research,[1] and has also been acknowledged as a critical element of clinical research by the current Presidential Commission for the Study of Bioethical Issues in their report, *Moral Science: Protecting Participants in Human Subjects Research*.[2] Since community engagement is now being recognized, including by the Federal government, as integral to the pursuit of good clinical research because of the need for researchers to understand the values and goals of the communities being asked to participate in moving the research forward, and since Catholic health care and the Catholic community are such a significant part of health care and of community life in the United States, one can readily conclude on this basis alone that the Catholic health care community has a significant obligation to bring its values and goals to the clinical research arena in order to make the procedures and regulations of clinical research all that more well-informed and well-constructed.

Exactly how this engagement between Catholic health care and the clinical research community should take place will require both adaptability and constancy on the part of Catholic health care institutions and the CHA. Due to the facts that 1) Catholic health care institutions may actually straddle both sides of the community participant/clinical research divide, 2) Catholic health care serves a variety of communities across the United States which have different values and goals themselves, and 3) Catholic health care institutions vary in their size and scope, and in the types of clinical research in which they are likely to participate, the ability to adapt Catholic values and goals to each set of circumstances will be key to achieving the best clinical research protocols for a given Catholic health care institution and its patients. At the same time, to provide standards by which the excellence of any clinical research protocol may be judged, constancy in valuing the dignity and ultimate worth of each and every human being involved in clinical research must be maintained.

It is not within the scope of this brief article even merely to list the range of possibilities for how this engagement might be done. Therefore, instead, the experience of one Catholic health care institution deeply engaged in both basic and clinical research, Georgetown University Medical Center (GUMC), will be offered as one example of how a Catholic health care institution worked to address the problem of clinical research protocols that contain requirements that conflict with Catholic values and find constructive solutions that support the research going forward in a manner arguably better than was originally proposed.

To fully explain the process that took place at GUMC with regard to the development of the procedures currently used in the adaptation and oversight of

clinical research protocols that have requirements or language that conflict with the Catholic moral tradition, a bit of history will be helpful. In the early 1990s, Dr. Milton Corn, Dean of GUMC, asked Dr. Edmund Pellegrino to establish a Center for Clinical Bioethics (CCB) that would be the nexus for "a concentration of clinicians with training and expertise in ethics located visibly and operationally in the medical center."[3] Though Georgetown University already had the prestigious Kennedy Institute of Ethics on the main campus, it was thought that the medical campus required its own ethics center to foster the continuing development of a culture of ethics throughout GUMC. Hence, the CCB was charged with providing ethics consult services that could respond on short notice to ethical dilemmas arising primarily in the clinical context, organizing and managing the hospital ethics committee, and creating an ongoing education program in bioethics throughout the hospital via routine participatory departmental rounds, in addition to taking charge of the ethics education of medical students.

In addition to the CCB, those at the medical center tasked with making decisions on a daily basis that involved application of the Catholic medical moral tradition, especially as articulated in the ERDS, in the increasingly complex biomedical research environment of GUMC, determined that they needed a consultative body to which they could turn for advice on how to apply the ERDs to new, emerging technologies, methods of care, clinical research, etc. Accordingly, that need was addressed by the formation of a committee of moral theologians at GU that could consider issues brought to them by those in the medical center who sought their guidance. This committee was formed and run through the GU President's office, with consultations managed by the GUMC Director of Research Assurance and Compliance, Sheila Cohen Zimmet, B.S.N., J.D.[4]

The first major case that came before this committee involved a multi-institutional clinical research protocol that involved the use of a thalidomide derivative to be tested in the treatment of cancer. Since the dangers of thalidomide, and its derivatives, to developing embryos and fetuses was well known, the consent form for this research protocol insisted that participants agree to avoid pregnancy while participating in the research. The only option given in the consent form for avoiding pregnancy was for the participant to agree to use two forms of birth control, with one form being a barrier method. The committee was asked to review this research project as its consent form had been flagged by the IRB and Director Zimmet to be in direct contradiction with the Catholic moral tradition and the ERDs. The committee agreed with this assessment of the consent form, and, hence, the research protocol was judged to be unacceptable for GUMC.

In response to this situation, Sheila Zimmet, called me at the Center for Clinical Bioethics to explore the possibility of GUMC responding to the research sponsors (in this case, the drug manufacturer) with alternative language for the protocol that would be in compliance with the ERDs and still achieve the goal of research participants agreeing to avoid pregnancy. Considering the amount of effort and review that goes into a multi-institutional, clinical research protocol, it was no small request to change the consent form and process to fit with the ERDs. However, GUMC was highly motivated to succeed in making this change as it would allow us to participate in good, cutting-edge, clinical research, and it would help the research project in making it more likely to reach its recruitment goals by being inclusive of the concerns of Catholics, Catholic health care institutions, and all others who share similar values and goals.

After many constructive exchanges of different proposals for adequate alternative language with the sponsors of the research project, who then had to

request the FDA to approve any language change, we were able to get the research sponsors to agree that we could modify the informed consent to emphasize the need to avoid exchange of bodily fluids, whether it was the female or male who received the study drug, and to emphasize that the most reliable method to avoid the risk of pregnancy was abstinence. Though this new language did not mirror the language proposed by the study sponsor to meet federal requirements, and to avoid liability if damage to a fetus occurred, it was consistent with the ERDs and was designed to provide equivalent informed consent to research participants.

The drug manufacturers/sponsors could also continue to provide their own information/educational packets/brochures regarding the risk of damage to developing fetuses and the means to eliminate the risk. While creating this consent process that incorporated the Catholic values of GUMC, we were also determined to provide a consent process wherein research participants would receive sufficient information to make informed decisions. Hence, in the end, we considered the overall research project to have been improved by our intervention as the alternative consent language allowed individuals to benefit from participating in this research who might otherwise have avoided enrolling in this research project due to their personal rejection of the use of artificial birth control in their own lives. In this way, we see this effort on the part of GUMC as facilitating and enhancing the concept of community engagement in clinical research. If the goal is to better integrate the values and expectations of communities in the United States into clinical research design and implementation, then what better group to help get more engaged in this process than the Catholic community and Catholic health care institutions, and all others who share these values?!

More recently we have asked successfully to include in Clinical Trial Agreements a recognition that abstinence is an effective method of avoiding pregnancy, and is an acceptable alternative to protocol language that requires the use of delineated birth control methods. We have taken this approach because we know how difficult it is to amend multi-center clinical trial protocols, and because we know that we can show sponsors how we can implement clinical trials in a manner that is consistent with our Catholic moral tradition and the ERDs, and in the interest of our research participants.

Perhaps most critical to any success we have had in integrating Catholic values into our clinical research enterprise is that fact that we have many key personnel in place, both on IRBs and in our administration, who readily support this integration—and many, including our now Senior Associate Vice President, Sheila Zimmet, are not Catholic. Because of these individuals and their efforts, the committee of theologians is no longer seen as a necessary piece in our research oversight process. Perhaps in the development of our research oversight process, which remains a work in progress, we have achieved some of the vision Dr. Corn and Dr. Pellegrino had for GUMC when they initiated the CCB. One recent expression of this culture of Catholic values and ethics we hope is still growing at GUMC is the acknowledgement that was given to the contribution made by Dr. Edmund Pellegrino in his steadfast focus on the good of the patient as primary in all things medical. This acknowledgement was the renaming of our Center to the Pellegrino Center for Clinical Bioethics (PCCB). Therefore, it is guided by his light and commitment that the PCCB and GUMC hope to continue moving forward in our pursuit of ethical clinical research that integrates Catholic values and is ultimately focused on the good of each and every human being.

[1] For more information on Community Based Participatory Research see: http://obssr.od.nih.gov/scientific_areas/methodology/community_based_participatory_research/

[2] Presidential Commission for the Study of Bioethical Issues (PCSBI). (2011, December). *Moral Science: Protecting Participants in Human Subjects Research*. Washington, DC: PCSBI.

[3] This quotation is from a brief history of the Center for Clinical Bioethics written by Dr. Pellegrino and obtained from his long-time assistant, Marti Patchell.

[4] Sheila Cohen Zimmet, Tony Moore, and Fr. Chris Steck, S.J., generously contributed their time and memories to assembling this brief segment of the history of the CCB and GUMC.