

# BIOETHICS NOTES

a newsletter from the Bioethics Review & Advisory Committee



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"Two things fill me with constantly increasing admiration and awe, the longer and more earnestly I reflect on them: the starry heavens without and the moral law within."  
Immanuel Kant (1724-1804)

## Investigational Therapies

By Jeremy Bennett

**Interpreting ethical conflict is the function of ethical rules.**

On June 12, 2008, a third revision of the [Access, Compassion, Care, and Ethics for Seriously Ill Patients \(ACCESS\) Act](#) (H.R. 6270) was introduced before the U.S. House. If passed, this legislation would create an 'exception label' to FDA regulations that would allow patients with terminal illness to be treated with medical therapies that are not yet FDA approved. Proponents of the Act argue that Phase III trials are too slow, and the use of placebo-controlled studies in Phase III trials is unfair to patients that may not survive to benefit from the treatments they are testing. Detractors of the Act contend that allowing early use of an investigational therapy is an unfair risk to patients, and would further slow down Phase III trials because it would be more difficult to find an adequate number of patients to act as controls in randomized studies.

The prevalent ethical conflict in this discussion occurs between the two bioethical principles of *autonomy* and *justice*. Patient autonomy is the right of patients to make decisions about their medical care without undue outside influence. Justice, in the distributive sense, is the need to maximize health care resources and distribute them equally and efficiently to all members of society who require them. Interpreting ethical conflict is the function of ethical rules. Many such rules exist, but the simplest and broadest are *intentionalism* (the analysis of an action's methods and goals) and

### MEET OUR COMMITTEE MEMBERS

#### JEREMY BENNETT

I am a fourth year medical student from Temple University. I enrolled as a Geisinger clinical campus student due to my interest in rural medicine and the excellent community to be found here, both inside and outside the hospital. My first exposure to formal ethics was through the Lincoln/Douglas debate program at the Danville Area High School, which inspired me to explore philosophy via additional debate, elective coursework, and private reading throughout my undergraduate and graduate education. I've been involved with the Bioethics Review and Advisory Committee for just over one year. My primary interests are in ethics, metaphysics, and the philosophy of knowledge.

*consequentialism* (the analysis of an action's expected outcome).

Intentionalism, in this case, would probably support the patient's request with a few caveats. The goal of the action is to give a patient freedom of choice in an uncertain matter, with the risks of the choice being fully borne by the patient. The means of the action, a change in legislation, is a matter of processing paperwork and is likely morally irrelevant. The known costs of the action, however, would also have to be borne by the patient. In the case of therapies without the benefit of widespread production and distribution, these costs would likely be high, and might make it impossible to actually receive the therapy.

Consequentialism, on the other hand, is less supportive. Even with the use of an incompletely studied investigational therapy, a net benefit to the patient isn't likely to occur – the success rate of such therapies in passing stage I-III clinical trials is about one out of five. (Pharmaceutical Research and Manufacturers of America, "[The Pursuit of High Performance Through Research and](#)

[Development](#)”, 2007). Of the four therapies out of five that fail, two will fail because they are ineffective, one because it is too expensive to implement, and one will fail due to the severity of side effects. This leaves roughly equal chances that a given therapy will have some beneficial effect for the patient, and that it will cause some severe side effect, although the extent of either possibility would be dependent on the therapy in question.

There are other outcomes to consider, including the empiric risk of interfering with the study of the therapy in question, and the costs of implementing a potentially useless treatment. At a policy forum in 2007, Dr. Ezekiel Emmanuel, the Chair of the Department of Clinical Bioethics at the NIH, discussed a similar process that occurred in the 1980's involving bone marrow transplantations as treatment for metastatic breast cancer. While the process underwent controlled randomized trials, several groups sued insurance companies to gain access to the therapy before results could be published. Ultimately, 40,000 patients received the treatment early, while the trial struggled for four years to find 1,000 patients willing to participate. He notes, “Bone marrow transplant made no difference whatsoever. As a matter of fact, it probably caused a lot of earlier deaths...it cost the country \$4 billion to get that data.”

Is it morally correct to perform an action that is intentionally defensible, but consequentially poor? There is no easy answer. In the case of the patient and doctor who are willing to accept the high monetary cost and risks of treatment, it seems acceptable to ask for it. The onus of performing successful research is not the direct responsibility of the patient, and it should be the patient's choice as to whether they would like to participate in such research to begin with.

Consequentialism is well suited for the comparison of competing rights claims, such as when one person's desire for better health and longer survival has costs that must be measured in risks to other people's health and survival. If it is likely that pursuing a treatment before its maturation and approval will deny others access to the same treatment, then allowing the patient to do so may be unfair. Unfortunately, whether allowing it *really is* unfair depends on many specifics of the case that

cannot be known until events play out: whether the therapy actually did work, or whether the Stage III trial of the therapy really was slowed down because some patients did not participate.

It is the obligation of governmental bodies to treat the rights claims of constituents equally. While it would be intentionally acceptable for patients to ask for treatment, it is also intentionally acceptable for the overseers of product research to deny that request in the hopes of saving more lives over time with a fully-approved therapy. Just as patients are not directly responsible for successful research, researchers are not directly responsible for the health of patients outside of their studies. In this case, consequentialism ought to be the deciding ethical rule.

Respectfully submitted,  
*Jeremy Bennett*