Published in final edited form as:

Int J Law Psychiatry. 2012 September ; 35(5-6): 380–386. doi:10.1016/j.ijlp.2012.09.003.

Competing Commitments in Psychiatric Research: An Examination of Psychiatric Researchers' Perspectives

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Abstract

Clinician-researchers have responsibilities both to seek the best interests of the people they treat and to advance scientific knowledge. The purpose of this study was to examine researchers' beliefs and behaviors regarding areas of tension between their clinical and scientific roles. We conducted and analyzed 19 in-depth interviews with psychiatric clinical researchers to explore these issues. Responses usually indicated that researchers recognize limits on their abilities to be helpful to patients, since they cannot know in advance whether a specific research intervention will help and whether participation is in the patient's best interest. Hence, most researchers did not make special efforts to recruit patients doing poorly in standard care, although they occasionally tolerated minor deviations from recruitment and treatment protocols when they might be in participants' interests. Often respondents asked the IRB to approve these deviations or change the protocol for all subjects, though it was unclear how often they may have acted without this approval. Despite researchers' high regard for following the research protocol, clinical judgment remained the ultimate guide if patients were not doing well and needed alternative care. Hence, respondents expressed a strong commitment both to protecting patients' interests and to advancing science. In cases of direct conflict between the two, many of the researchers tended to promote patients' best interests even at some cost to scientific research.

Introduction

Clinician-researchers are caught between two sets of commitments (Angell, 1984; Appelbaum *et al.*, 1982; Lidz & Appelbaum, 2002). As clinicians, charged with patient care, they have a responsibility to seek the best interests of each person they treat (Hellman &

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Conflict: No author has a financial conflict of interest to report.

Hellman, 1991; Marquis, 1983). But as researchers, charged with advancing scientific knowledge, their responsibilities are to implement research protocols faithfully and to generate reliable data (Hellman & Hellman, 1991; Lidz *et al.*, 2009; Miller & Rosenstein, 2003). When these responsibilities conflict, clinical researchers are often left searching for resolutions to the tension between their roles.

The potential for conflict in commitments for clinical researchers arises in part from the techniques used to insure the validity of their data. For instance, researchers may possess preliminary, but not dispositive, data suggesting that one treatment is superior to another; in ordinary clinical care such evidence might be sufficient to govern their treatment recommendations, but in the research setting they will continue to randomize subjects between these options, knowing that one group will receive what appears to some clinicians to be inferior care (Angell, 1984; Hellman & Hellman, 1991; Marquis, 1983). Similarly, for the sake of producing valid results, researchers may subject research participants to medication washout periods, restrictions on adjunctive treatments, and dosing restrictions, all of which can increase risks or discomforts for subjects (Appelbaum *et al.*, 1987; Lidz *et al.*, 2009; Miller & Rosenstein, 2003). At the same time, participants may undergo blood sampling, imaging, or biopsies that may create only minor risks but offer them no direct benefits. Researchers often use placebos, which are designed *not* to provide physiologic benefit, in place of active treatment (Lidz & Appelbaum, 2002), and may forego knowledge of what treatment is being received (blinding), leaving them in the dark with regard to side-effects and interactions (Appelbaum *et al.*, 1987).

The conflicts faced by clinical researchers have occasionally surfaced when an investigator is found to have deviated from a study's rules, calling into question the validity of the results. A notable example is Roger Poisson, a surgeon and principal investigator with the National Surgical Adjuvant Breast and Bowel Project (NSABP) who made headlines for generating "falsified data" (Weijer *et al.*, 1995). In 1990, it was discovered that he misreported patients' medical information so that they would meet enrollment criteria. Most discrepancies involved dates, a few involved hormone receptor values, and three involved cardiac history; 111 of 1511 records were affected (Weijer *et al.*, 1995). In the wake of the discovery of his actions, he resigned from all administrative positions at the hospital and accepted compulsory retirement from his position as full professor at the university, where he was barred from any teaching activity (Huett, 1994). He explained his viewpoint:

...I felt that the rules were meant to be understood as guidelines and not necessarily followed blindly. My sole concern at all times was the health of my patients. I firmly believed that a patient who was able to enter into an NSABP trial received the best therapy and follow-up treatment. For me, it was difficult to tell a woman with breast cancer that she was ineligible to receive the best available treatment because she did not meet 1 criterion out of 22, when I knew that this criterion had little or no intrinsic oncologic importance... Clinical trials are difficult to perform in practice, even if they are good in principle. Maintaining the proper balance between good clinical care and rigid research methods is not an easy task (Poisson, 1994, p. 1460).

There has been little empirical study of how clinician-researchers navigate the tensions between their two roles. In a prior survey of 741 clinical researchers, we found evidence suggesting that clinical concerns may sometimes lead researchers to compromise their approach to research (Lidz *et al.*, 2009). In that survey, 90% of respondents agreed with ignoring "minor entry criteria," 83% considered the protocol "a guideline rather than something to be strictly followed," and 64% said that researchers should deviate from the protocol if it would improve the subject's medical care (sentiments similar to Roger Poisson, quoted above). Additionally, while subjects have long been known to misconstrue the

degree to which clinical trials reflect the therapeutic goals of ordinary treatment (the “therapeutic misconception”) (Appelbaum et al., 1982; Appelbaum et al., 1987), there is some evidence that researchers share this tendency, with 33% of survey respondents saying researchers should only participate in trials that are likely to help the subjects who take part (Lidz et al., 2009). These findings raised questions about the frequency and significance of these deviations, and whether they were reported to Institutional Review Boards (IRBs) and study sponsors. However, since the data were derived from a survey, in which subjects’ responses could not be explored further, it was difficult to draw firm conclusions about the impact of their behavior on the clinical research enterprise.

The current study is an attempt to expand on these earlier findings, by addressing these issues in one-on-one interviews with clinical researchers. Questions focused on researchers’ attitudes and behaviors when faced with the competing commitments of providing optimal patient care while meeting the demands of conducting rigorous scientific clinical trials, with follow up questions to ascertain the significance of their responses. The full set of interviews included researchers from a variety of fields, but this paper focuses on psychiatric researchers, a group of particular interest given the heightened scrutiny to which psychiatric research is often subjected (Roberts & Roberts, 1999; Wisner *et al.*, 2011).

Methods

Participants

Participants in this study were 126 clinical researchers from diverse fields of medical research, who were recruited from four large academic medical centers in the U.S. The research office at each site helped to identify principal investigators and project coordinators currently working on phase 2 and/or 3 clinical trials. Researchers were invited via email to participate in a single in-person interview. Project coordinators were included because they often had the most contact with subjects and could be in a position to make decisions, for example, as to whether subjects met entry criteria. Data reported here come from a subset of the 19 psychiatric researchers drawn from the larger, non-random sample. The characteristics of the participants are shown in Table 1.

Interview Instrument

Items from the previous survey (Lidz et al., 2009) were adapted for use in a semi-structured interview. Follow-up questions were added to be used when participants reported attitudes and/or behaviors that prioritized patient well-being above study protocols. For example, if a participant responded “agree” or “mostly agree” to the statement, “The protocol should be used as a guideline rather than something to be strictly followed under all circumstances,” the interviewer followed-up by asking about the types of circumstances that would lead the researcher to deviate from the protocol, whether the deviations were reported to the sponsor, and how frequently such behaviors occurred. Interviewers from all 4 sites participated in an intensive, 3-day training session on administration of the semi-structured interviews with the study principal investigator (CL) and project director (KA). Interviewers were trained to encourage conversation about the topics raised by the particular questions and to make extensive use of follow-up probes. After demonstrations of interview technique, each interviewer had the opportunity to conduct mock interviews for practice and feedback.

Data Collection

Following signed, informed consent, interviews were conducted and audio recorded. The site PIs conducted the first few interviews at their sites while the interviewers observed. After completing this final phase of training, the interviewers conducted the remaining interviews, which ran approximately 45 minutes.

Data Analysis

All interviews were transcribed for analysis. An extensive codebook was developed and implemented by the PI (CL) and the Project Director (KA) and implemented with a trained coder whose reliability was periodically assessed, with retraining when necessary. Two of the authors (KA, CL) used this system to review the issues addressed here for the entire sample. The first author (RL) performed an analysis in which he read all of the psychiatric interviews in full to review the responses in the context of the entire interview so as to better appreciate the individual interviewees' understanding of the issues.

The study was approved by the institutional review boards at the coordinating site (University of Massachusetts Medical School) and each participating site.

Results

Demographic characteristics are shown in Table 1. Researchers being interviewed were offered a series of statements probing their attitudes towards conflicting obligations in clinical research, beginning with the decision to undertake a study, through the recruitment process, and continuing through the study itself. For each statement, they were asked to indicate their degree of agreement or disagreement, and their responses were then probed to explore the bases for their views.

Recruitment: "Researchers should only participate in trials that are likely to help the subjects who take part."

Many participants balked at the suggestion that researchers should only participate in trials likely to help the subjects who take part. Objections came in two forms. One objection underscored that the very purpose of the trial is to determine whether an intervention is beneficial. "You don't know until you do the study" (323, also 225, 233, 303, 310, 331, 320, 417).

The other objection emphasized that trials are not intended to help participants, but to advance science or to help society. One respondent explained, "In research typically the goal isn't usually to help people who are in that particular project, it's kind of to help the greater population in general" (303). Another said, "Sometimes it's not to benefit that person but to learn something more about a disease or a treatment" (231, also 222, 225, 228, 229).

However, many respondents thought that there should be some indication that a treatment is likely to be helpful (224, 233, 310) or at least not known to cause harm (222, 224, 310, 318, 320, 323) before a decision was made to participate.

Some researchers thought it was possible to design trials where participants would always benefit in some way (303). Benefit might come in the form of a special consultation or diagnostic evaluation, or active treatment following the trial (232). A weight loss researcher, for example, said that all of his participants received a behavioral intervention, so whether they received placebo or active medication, all participants might benefit from the trial (222).

Recruitment: "Patients who are not doing well with standard care should be recruited most actively so that being in the trial can help them."

Most researchers did not support specifically recruiting patients who are not doing well with standard care, instead saying that they recruit whoever is available (305, 318, 331). Of course, trials studying treatment refractory patients were an exception (222, 224, 315, 331).

There was more division on whether to recruit patients who are already doing well on their current regimens. Some believed that when patients are doing well on standard care, “There’s no reason for them to be in a trial. They can’t possibly get anything out of it” (225, also 224, 231, 310). However, others noted that patients could be recruited if the trial offered something even better than their current regimen.

“Probably they don’t need to be recruited, I mean, unless there’s something better that you’re offering them you know like, fewer side effects...[Say] you’re on an antidepressant but you gained 40 pounds, and we have an antidepressant that doesn’t have weight gain...” (315)

In the middle were those who would offer patients the choice (323, 331).

Other respondents tended not to wrestle with questions about which patients to pursue, noting that pragmatic factors could make the issue moot: patients are less likely to enroll if they are doing well (224); an IRB is less likely to approve a protocol that requires stable patients to change their medications (222); and protocols often exclude patients who are doing well (225, 229, 231, 233).

Of note, this question and (several others below) included an explicit assumption that participating in the trial would benefit the patient. Some researchers agreed that participation would benefit the patient (“Trials sometimes offer them something that they can’t get elsewhere” 225, also 224, 228, 232, 315, 331). However, other researchers commented (for this question and for questions below) that they never know in advance whether the patient will benefit from participation (231, 232, 233, 303, 305, 417).

Recruitment: “Even if patients are technically eligible for a trial, they should only be recruited if it will be in their best interests.”

Many researchers would not recruit an eligible patient if the trial clearly would *not* be in the patient’s best interests (225, 231, 233, 303, 320, 331). Some assumed that exclusion criteria would remove patients for whom participation was clearly *not* in their best interests (222, 231, 315, 426). But they also gave examples of turning away patients with a history of severe mental illness who only recently stabilized (320), who were clinically tenuous (228), or who might not tolerate a medication washout period (305). Most responses were consistent with the idea that recruitment should be deferred, and perhaps reconsidered in the future, “if it was delaying the person’s getting a proven effective treatment and delaying [treatment] is not in their best interest” (233). For a few researchers, concern for the patient’s best interests extended to non-clinical factors like time commitment (for full-time workers [228] or teenagers [331]) and difficulty with transportation (228)—issues that may not be addressed by eligibility criteria.

Some researchers who had concerns about a trial not being in the patient’s best interest, would invite the patient to return at a later date for re-evaluation (320), refer the patient to another trial (225), or refer the patient to another clinician for treatment (303). Some pointed out that, in psychiatric clinical trials, the same treatments are often available in non-research settings, so patients need not risk randomization or medication stoppage to obtain particular drugs (224, 305).

On the other side, though, some researchers said they could not base recruitment on the patient’s best interest, because they did not know what was in the patient’s best interest (231). The intervention might not be effective (233, 310, 331) or the patient might receive placebo (224, 331). According to several respondents, only the patient can decide what is in his or her best interests (222, 232).

...for a recruiter or a researcher to say, “This is in your best interest and you should do this,” or “I don’t really think that’s in your best interest so you shouldn’t do it,” is not [appropriate]. The participant should be able to make that decision for themselves. (323)

In the absence of clear indication about what is in the patient’s best interest, some researchers deferred to the informed consent process for the ultimate participation decisions, a process that is consistent with respect for subject autonomy. (222, 224, 305, 310, 331, 426). One researcher said, “Ultimately I see the informed consent process as being the most critical thing...” (222). Another explained,

...that’s up to them. So I’m still going to try and recruit anybody. This woman who just lost her nephew who was like a son, it might not be a good idea for her to participate in the study. She’s already been randomized so we’d like her to, but it may not be in the best interest, and so I’m sort of neutral in that way. I guess I agree [with the prompt], but it’s their decision. (318)

In addition to protecting the patient’s best interest and relying on informed consent, researchers also based some recruitment decisions on a desire to protect the trial.

[If] there is worry that their symptoms might exacerbate then they shouldn’t be put in a clinical trial. Also then any side effect that they show that’s significant throughout the clinical trial is going to be looked at as an adverse event, and it might not be reflective of the study medication (228).

However an opponent of that perspective argued, “What kind of research are you going to have if you pick the perfect patient to go in for that study, and you get all positive results?” (419)

Recruitment: “It is okay to make exceptions to minor entry criteria if a patient will benefit from being in a trial.”

Many of the researchers expressed reluctance to make exceptions to inclusion criteria (222, 225, 231, 233, 303, 318, 320, 323, 331, 417, 419, 426), saying “you need to follow the protocol” (419) and “the main goal here is to answer the question in the most scientific way you can possibly do it” (417).

However, researchers also believed that some criteria are more significant than others (“It wouldn’t have any kind of effect on our outcome data or the intervention so we dropped the criteria” [303]). Scenarios where researchers were inclined to make exceptions included age cutoffs (e.g., “their birthday is in 2 weeks” [232, 305, 310]), duration of symptoms (“[it’s] hard to date the onset of a full psychotic disorder” [331]), lab values (liver and blood values “just above the criteria” [228]), depression rating scores (just below threshold—“that can be analyzed statistically” [315]), and body mass index (222).

...patients were being excluded based on this well-intentioned but ultimately arbitrary cutoff... the decision to have that BMI cutoff was not made by a clinician... it was from someone who was used to doing pharmacokinetic laboratory-based research with animals and healthy controls. (222)

When a minor criterion was interfering with recruitment (especially early in the trial [222]), some researchers described discussing it with the IRB (222, 224) and the study sponsor (228), and would either request an exception (305) or change the criterion for everybody (222, 303).

However (responding to another question), some researchers expressed a willingness on occasion to enroll subjects despite screening ineligible - if it seemed consonant with

subjects' interests - and did not explicitly mention appealing to the IRB or formally altering the protocol. One researcher recalled patients with "a different diagnosis that would technically have ruled them out. But we knew enough about their other diagnosis and we could figure out how to make it work" (232). Other apparent exceptions were made for symptom duration or patient age just beyond the cut-off (323, 331).

Recruitment: "Researchers should recruit all eligible patients even if the subjects plan to drop out if they don't get into the treatment group that they want."

Most researchers reported that they would not recruit a subject who expressed a plan to drop out if he or she did not get the preferred treatment arm. Some expressed a concern that the practice would cause "lopsided randomization" (231) or could "compromise the validity of the trial" (225, 315). At the very least it would waste time (225, 228). A number of respondents believed that patients who were unwilling to be randomized were not eligible for the trial (310, 320, 323, 331).

By saying that they're going to drop out if they don't get the treatment group they want, they basically have not given consent to participate in the study as far as I'm concerned. (305)

However a few researchers said they would enroll eligible patients who threatened to drop out if they did not get the treatment group they wanted. One reason was that "people often change their minds...they fall in love with you or the trial or the research team and do it" (417, also 419). Another said "You can't just recruit patients that [promise] they're going to go through no matter what. You've got to take the chance" (419).

Researchers addressed this issue by being very clear about the randomization process during the informed consent phase (303, 323, 419), by making both treatment arms appealing (323), by indicating that both arms are likely to be beneficial (323), and by offering participants the opportunity to switch arms after follow-up (310). However problems remained when the treatment arms were clearly different (16-week intervention versus a 2-hour workshop [303, also 222]) or when patients could only attend psychotherapy groups on specific nights of the week (310).

Conduct of the Study: "The protocol should be used as a guideline rather than something to be strictly followed under all circumstances."

Many disagreed with this statement, stating "the protocol is the protocol" (305), "it should always be followed" (426, also 222, 224, 225, 233, 331, 419). One described it as "more than a guideline actually. It's an agreement that you have with your IRB and with the patient and the consent form and then the whole process" (224).

However, some researchers were inclined to make exceptions, or to amend the protocol. Patient safety was one motive (228, 231, 303). Additionally, "A specific person ...might not always... fit exactly what's supposed to be done in the protocol" (229). (See also quote from 224 in the following section.) Protocol cutoffs might be arbitrary, as with age limits (232) or maximum drug dosages:

...because somebody in the previous research wrote four [doses], we also wrote four. So I would rather adjust the protocol if the patient needs five, if I don't think it will influence the research. (417)

Other concerns were that "something unanticipated" could arise that "could be potentially harmful to the research patients" or a new development could potentially benefit participants (e.g., free Hepatitis A and B vaccines [320]). Additionally, specific populations (e.g., opiate users [318]; nonagenarians [303]) can be unpredictable.

Researchers thought that some protocol deviations were problematic, while others were not.

I think that if we're talking about the intervention, I think that we do have to strictly follow the protocol unless it's not in the best interest of the participant... But if we're talking about... follow-up research assessments and a lot of structured clinical interviews and neuropsych testing, on that end I think that we have to be a little more lenient. (303)

Conduct of the Study: "Researchers should make exceptions to the protocol if doing so would significantly improve the subject's medical care."

Many disagreed with the prompt and would not make exceptions (225), because protocol deviations "influence the science" (417) and make it difficult to answer the research question (303, 417). Moreover, the researchers "agree[d] to do the protocol according to what the protocol is and that's it" (419). Others said, "You can't just do that because you're funded to do the study. The study is funded to do a certain thing and so you should stick to that" (305). "In fact you've signed an agreement saying that you won't do that" (233).

On the other side, some thought occasional protocol deviations were justified. This is because "Researchers always have to weigh what's for the general benefit of the research study versus what's the particular benefit to the individual patient" (224). Protocol deviations were described as reasonable if changing the protocol (for everyone) would improve clinical outcomes (310), if changes "don't affect the science" (232), or if the deviation happens only occasionally (229). Specific examples of "acceptable" deviations were: changing the consent form (318), changing recruitment techniques (318), changing the psychotherapy modality (e.g., talking by telephone [229]), including patients who did not exactly meet the age requirements or whose "clinical picture might not exactly fit the criteria" (229), and helping "with co-morbid issues also if they came up" (229).

When clinical care required a change in treatment, researchers sometimes did not feel constrained by the protocol. In part, they expected protocols to contain contingency plans for patients who clinically worsen (310, 331, 426). However, if a subject could not be treated within the protocol, researchers would consider withdrawing the patient from the trial to provide appropriate clinical care (222, 233, 303, 305, 310).

Termination: "Clinical judgment, not the protocol, should be the basis for deciding to remove subjects who are not doing well."

Researchers generally agreed that clinical judgment should always guide decisions about removing subjects from trials. Moreover, there was consensus that protocols should (and usually do) integrate clinical judgment with regard to removing subjects from a research study.

I think most protocols have dropout criteria and they usually have clinical judgments as being one of them. I think it's important that clinical judgment always be able to trump the protocol for the safety of patient welfare. (233)

Generally clinical judgment was given priority over the protocol when it seemed termination from the study was in the subject's best interest.

The protocol can't envision all contingencies. So the protocol may have removal criteria, but there may be other reasons that nobody thought of to remove someone and so clinical judgment would trump that. (225)

The only contrary example offered involved a patient who met criteria for discontinuation (and was removed), but researchers thought he was not actually doing poorly.

When he first came [he] was not very talkative... he didn't really endorse anything. And as he became comfortable in the study he came in with like two pieces of paper with somatic problems that he was having, and it turns out that none of these were new. He just never revealed it at the beginning... but [the protocol] was written to say 'if an increase of two or more on this item, the patient has to be removed from the study.' (228)

Termination: "Unless the protocol is clear that they must be removed, subjects should only be removed from trials with the agreement of the sponsor."

None of the researchers believed subjects should be removed only when the sponsor agrees. Most noted that the sponsor needs to be notified if a patient is being dropped from the trial (222, 305, 310, 323, 417, 419). However clinical judgment has priority (222, 225, 228, 231, 233), and patient safety should always come first (228, 229, 303, 310).

Researchers' experiences with funding agencies were more often the opposite. Sponsors rarely got involved in the decision (225, 233, 305, 323), but when they did, it was to recommend that a patient be dropped from the trial (305).

...they don't press you to keep them in the study. That's been my experience. It's usually the other way around. It's the sponsor who's saying, "Well, you know, maybe you should take this person out." "No, they missed a couple of visits or whatever, but I think that they can still complete the protocol successfully." It's more that they have very strict rules; you know, "You're four days late for one visit, you're out of the window. The window only is three days; four days you're out." Well, it's a little rigid. Sometimes sponsors will have very rigid protocols that don't quite map to the contingencies of real clinical work. And the rigidities will often say, "Oh, the person's non-compliant." Well, they're really *not* non-compliant. You know, it was a holiday weekend; they couldn't get a babysitter; there was a snowstorm. So they're out of the window, so what? They're out of the window. One day isn't going to make a whole lot of difference. So sometimes the protocols are a little too rigid. That's been more my experience than the other way around that I've wanted to take someone out and the sponsor pressed me not to. I've never seen that happen. (225)

Discussion

Two overarching themes emerge from these interviews. One is that psychiatric researchers are fully committed to protecting the interests of individual patients, as illustrated by their statements about obtaining informed consent, designing trials that benefit all participants, and withdrawing patients who need a higher level of care. The other overarching theme is that researchers are equally committed to abiding by research protocols, which is evident in their statements about adhering to recruitment criteria, avoiding protocol deviations, protecting the science, and including the IRB when changes need to be made. Allowing researchers to elaborate their views through in-depth interviews provides a reassuring counterbalance to some of the concerning findings reported in the previous survey, such as 33% of respondents saying "researchers should only participate in trials that are likely to help the subjects who take part," or 64% endorsing the statement that "researchers should deviate from the protocol if doing so would improve the subject's medical care."

Despite researchers' uniform commitment to these two goals (or perhaps because of their dual commitment to potentially incompatible goals), we identified some areas of disagreement. We found mixed opinions regarding whether participants' interests should

determine decisions about which trials to undertake, whether to enroll all patients who screen eligible, and when it was appropriate to change or make exceptions to the protocol.

The topic of when to make changes to the protocol and what counts as a “minor deviation” warrants special attention, especially since prior survey results indicated 83% of researchers who responded believed the protocol is a “guideline rather than something to be strictly followed,” and 90% agreed that “it is acceptable to disregard minor entry criteria if a patient will benefit from being in a trial” (Lidz et al., 2009). In our interviews, researchers appeared torn between desiring rigorous adherence, yet also feeling constrained by “arbitrary cutoffs” that “do not affect the science.” The list of exceptions that researchers mentioned was surprisingly broad: lab values, symptom duration, body mass index, dosages, diagnoses, and treatment adherence requirements were all mentioned as legitimate deviations, even though some do not seem very minor. The challenge in exploring this topic may be that the research ethics literature is so clear that protocol deviations need to be IRB-approved except in an emergency (Eckstein, 2003) that it is hard to get professional researchers to talk about the gray zone where a decision is not entirely in line with the protocol, but not so far out of line that it clearly requires IRB involvement. Given the time and energy it takes to apply for protocol exceptions and changes, there is likely some threshold for getting the IRB involved, but describing that threshold is difficult for all involved.

Although the prior survey indicated that 96% of researchers experienced moments of conflict between their clinical and research commitments (Lidz et al, 2009), our interviews did not indicate that researchers routinely ignore patients’ needs in the pursuit of scientific knowledge. Understandably, this possibility has been a focus of the bioethics literature, which has long been concerned that clinician-researchers may have to choose between protecting patients and protecting the dataset (Hellman & Hellman, 1991; Lidz & Appelbaum, 2002; Oberle & Allen, 2006). Hellman and Hellman (1991, p. 1588) exemplified this position when they argued, “Randomized trials *often* place physicians in the ethically intolerable position of choosing between the good of the patient and that of society” (emphasis added). Based on these interviews, this concern may be overstated, as researchers were strongly oriented toward protecting individual subjects’ best interests. If a participant needed a treatment not permitted by protocol or if the patient were at risk for doing poorly in the study, researchers preferred to remove the subject or to defer enrollment, rather than place the subject at risk or violate the protocol.

A substantial body of literature documents the inappropriately high expectations often manifested by research participants, especially the assumption that clinical research will share the therapeutic goals of ordinary treatment (the “therapeutic misconception”) (Appelbaum et al., 1982; Lidz & Appelbaum, 2002). Some authors have been concerned that many researchers similarly share that view (Miller & Rosenstein, 2003; Miller *et al.*, 1998). In these interviews, however, there was only equivocal evidence of therapeutic misconception on the part of our respondents. Researchers held a range of beliefs, and although some clearly thought that clinical trials would benefit participants, this was not always a misconception. Some researchers specifically designed their trials to benefit all participants in some way; perhaps providing expert assessment, close follow up, or patient education. Others noted that behind every clinical trial there exists *some* evidence that an intervention may help, even though the evidence might be preliminary or theoretical—a riskier assumption when the benefits are unproven, the chance of harm is unknown, and many participants will receive placebo. Miller and Rosenstein have criticized this “therapeutic orientation to clinical trials” saying it obscures the “ethically significant differences between clinical research and medical care” (Miller & Rosenstein, 2003). Although their point is well taken, these interviews suggest that many psychiatric clinical trials have a substantial therapeutic dimension.

It is worth highlighting that our results pertain to psychiatric research, a field with some attributes that, although not unique, are often more prevalent than in other areas of medical research. Psychiatric clinical trials frequently employ medications that are already widely available in clinical settings. In addition, psychiatric medications have variable effect sizes, although in the aggregate they are not less effective than medications used in other areas of medicine (Leucht et al., 2012). That some psychiatric research involves talk therapy also makes it distinct from some other types of clinical trials, since subjects who engage in talk therapy play an active role in their treatment, compared with many medical interventions where something happens to the person. Finally, persons with psychiatric disorders may manifest impairments in decisional capacity to consent to research, although the available data suggest that this is less frequent than often thought (Appelbaum, 2006; Appelbaum et al., 1999). Nevertheless, the potential for reduced decision making capacity suggests researchers need to exercise extra moral vigilance when designing trials and recruiting many groups of psychiatric patients.

A particular issue, although probably not unique to psychiatric research is the balance of patient autonomy versus medical paternalism. The paternalistic drive can be especially strong when the researchers want patients to enroll; perhaps believing that an experimental treatment will benefit the patient, hoping that any form of research participation might become a doorway to engaging patients in treatment, or feeling frustrated if the patient has short-sighted reasons for declining study participation (e.g. scheduling conflicts, transportation hassles, poor organizational skills, or fear). In our data, researchers did show considerable hope that participation would benefit patients, but were far from paternalistic in stating that experimental treatments are unproven, and in expecting patients to decide for themselves. Although all researchers should guard against being overly paternalistic when recruiting patients, psychiatric researchers can take some comfort in data suggesting that even severely ill psychiatric patients tend to support research more than psychiatrists predict (Roberts et al., 2000).

This study has several limitations. The recruitment strategy did not target a precisely defined population, resulting in heterogeneity among participants (varying levels of training, varying roles on the research teams, and diverse research endeavors). The sample size was modest (19 interviews), and participants were not randomly selected. These considerations, along with the qualitative methodology of the study, limit our ability to estimate the prevalence of attitudes and behaviors. We cannot describe these attitudes as representative of all psychiatric researchers, much less of clinical researchers in general. However, given that we had previously collected survey data on these questions from a much larger sample, our goal was the far more modest one of shedding light on the implications of those earlier data. Although all participants were engaged in psychiatric research, they had diverse training and interests, and studied different patient populations with varying research methods. Hence, the heterogeneity of their responses may reflect the different experiences they bring to the interview setting. Respondents were reacting to specific questions and a necessarily limited number of probes, perhaps leaving important areas unexplored. Moreover, the interviews were an extension of our prior survey, which potentially constrained the types of questions we asked. Finally, when reviewing the transcripts there were points where participants made comments that were not entirely consistent with earlier statements. For example, participant 224 stated the protocol is “more than a guideline actually. It’s an agreement that you have with your IRB and with the patient and the consent form and then the whole process,” yet later gave examples of making exceptions to minor entry criteria and agreed with the statement that researchers should make exceptions to the protocol if doing so would significantly improve subjects’ medical care. These ambiguities serve as a reminder that brief interviews and qualitative analyses provide samples of people’s beliefs, and highlight

the complexity of their opinions, but do not necessarily generate a comprehensive understanding of their views.

Notwithstanding these limitations, our data suggest that many psychiatric researchers do experience tension between protecting patients' interests and faithfully implementing research protocols. Overall it is reassuring that researchers remain oriented both to protecting patients' best interests and to guarding the integrity of their research data. In their report on "Responsible Science," the National Academy of Sciences stated, "Basic to the honor system that binds the community of scientists is truthfulness, both as a moral imperative and as a fundamental operational principle in the scientific research process" (Panel on Scientific Responsibility and the Conduct of Research et al., 1992, p. 17). Our data indicate that psychiatric researchers largely strive to present data that are what they claim to be, while not compromising patients' interests.

Acknowledgments

Funding: Supported by grant 1RC1 NR011612-01 from the National Institute of Nursing Research (Charles W. Lidz, principal investigator).

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Table 1

Demographic Characteristics of participants

Sex	N
Female	15
Male	4
Race	
White, non-Hispanic	16
Hispanic	2
Unidentified	1
Degree	
MD	7
PhD	5
Masters	4
Bachelors	2
Registered Nurse	1
Research Position	
Principal Investigator, or Co-Principal Investigator	11
Nurse or Nurse Practitioner	3
Non-Clinical coordinator	3
Director	1
Research Associate/Assistant	1

Years working on clinical trials: range 5-30 years, mean 11.7 years