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August 6, 1996

TO: Distribution List

Re: T.D., et al. v. The New York State Office of Mental Health, et al. - New York County Index No. 5136.91

Enclosed please find a copy of the amicus brief filed today in the above-referenced action.

Please call with any questions.

Sincerely,

Lynda Schuler

Enclosure

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SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

T.D., et al. Plaintiffs-Respondents-Appellants V. THE NEW YORK STATE OFFICE OF MENTAL HEALTH, et al. Defendants-Appellants-Respondents.	)	INDEX No. 5136/91 (New York County)

BRIEF FOR PROPOSED AMICI CURIAE THE BAZELON CENTER FOR MENTAL HEALTH LAW, CITIZENS FOR RESPONSIBLE CARE IN PSYCHIATRY AND RESEARCH, THE CONSUMER INFORMATION NETWORK, DISABLED IN ACTION OF METROPOLITAN NEW YORK, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, THE LAMBDA LEGAL DEFENSE AND EDUCATION FUND, INC., THE MENTAL HEALTH EMPOWERMENT PROJECT, INC., THE NATIONAL ASSOCIATION FOR RIGHTS PROTECTION AND ADVOCACY, THE NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES, THE NEW YORK CITY ENVIRONMENTAL JUSTICE ALLIANCE, THE NEW YORK CITY RECIPIENTS' COALITION AND THE UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC.

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SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

T.D., et al. Plaintiffs-Respondents-Appellants V. THE NEW YORK STATE OFFICE OF MENTAL HEALTH, et al. Defendants-Appellants-Respondents.	INDEX NO. 5136/91 (New York County)

BRIEF FOR PROPOSED AMICI[1]

It defies belief that, within the last 50 years, researchers in this country have experimented on unsuspecting human subjects by infecting them with live cancer cells and hepatitis, exposing them to radiation and chemical warfare agents, and refusing to provide available treatments for the syphilis which, they are not told, explains their suffering. While we cling to the illusion that such incidents are aberrations from the distant past, the reality is otherwise. Disproportionately, such experiments are conducted on individuals with mental disabilities. Unfortunately, even the best intentions of the researchers cannot compensate for the inherent conflicts they face in decisions regarding their own experiments, or for the often devastating

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[1] See Affirmation in Support of Motion for Leave to Appear as Amici Curiae, attached hereto as the Appendix, for a list of the amici and a detailed description of their interests and their work on behalf of persons with disabilities.

impact on the life and autonomy of their subjects. These are the lessons of history. This Court has before it the opportunity to ensure that history does not repeat itself in the State of New York.

I. Introduction[2]

Plaintiffs are six individuals involuntarily committed to New York State psychiatric facilities who have been adjudicated incapable of consent and subjected to medical treatment (electroshock therapy or psychotropic medications) over their objections after court hearings. They challenge regulations promulgated by the Office of Mental Health ("OMH") that subject patients incapable of consent to research that is of greater than minimal risk[3] yet holds out no prospect of direct benefit to the patient (i.e., it is "non-therapeutic"). N.Y.C.R.R. tit. 14, § 527.10 (1995). Also at issue is therapeutic research of greater than minimal risk undertaken without prior court determination of the patient's incapability, what the patient would have wanted and/or the patient's best interest. Id. Plaintiffs further challenge the regulations applicable to

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[2] A detailed summary of the underlying facts and claims are set forth in Plaintiffs/Respondents' Brief before this Court.

[3] "Minimal risk means that the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests." N.Y.C.R.R. tit. 14, § 527.10(c)(6).

children insofar as they permit either non-therapeutic research, or therapeutic research undertaken without parental consent. § 527.10(e)(3). Of the 400 ongoing research projects being conducted at OMH facilities, only 10 fall within the challenged categories. R. 25.

While involving a small number of patients, the research at issue can have a profound impact on the incapable adults and children subjected to it. Patients enrolled in OMH research projects have suffered in many ways, including sudden cardiac death, suicide (by such means as setting oneself on fire), seizures, hepatitis, hallucinations, loss of consciousness and memory, and cardiac arrhythmias. Many experiments involve such invasive procedures as lumbar punctures (spinal taps), brain scans (involving radiation exposure), skin biopsies and prolonged use of intravenous lines. R. 2474, 2487, 2504, 1123, 2485, 423, 722, 1540. Research into the causes and possible cure of schizophrenia, which is conducted by OMH, is particularly high risk. See Richard Ketai et al., Family Influence in the Recruitment of Schizophrenic Research Subjects, 138 Am. J. Psychiatry 351, 351 (1981) (discussing possible injuries resulting from procedures which can be "drastic and invasive" and side effects from medication). See also Richard Jed Wyatt, Risks of Withdrawing Antipsychotic Medications, 52 Arch. Gen. Psychiatry 205 (1995).

One critical flaw in the OMH regulations is the unfettered control accorded the researcher in obtaining a patient's

"informed consent." The challenged regulations do not require court adjudication of incapacity, but rather permit an interviewer -- who can be a member of the research team -- to determine whether a patient is capable of consenting to research. R. 2635. Once deemed incapable of consent, the adult patient need not be informed of the proposed research, and his "assent"[4] is not required. Rather, the researcher may seek surrogate consent from any of the following: a spouse, parent, adult child, adult sibling, guardian, or a committee of the person authorized to consent to research. § 527.10(e)(2)(iv). If no one in those categories exists, a "close friend"[5] or a court of competent jurisdiction may consent. § 527.10(e)(2)(iv). Once consent is obtained from one of these sources, the research may proceed, regardless of whether others on the list voice an objection; the regulations do not provide that the objection of

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[4] "Assent" is defined in the regulations as "an affirmative agreement to participate in research. Mere failure to object shall not, absent affirmative agreement, be construed as assent." The assent of patients under 18 years of age is required, § 527.10(e)(3)(iv); no assent is required for any other patients if they are deemed by OMH to be incapable of providing informed consent. The Institutional Review Board ("IRB") can waive the assent requirement for children, however, if it determines the child is so limited that he cannot reasonably be consulted, and may make this determination for an entire group of subjects. Id.

[5] "Close friend" is defined as "an adult who presents an affidavit to the director which states that he is a close friend of the patient and that he has maintained such regular contact with the patient to be familiar with the patient's activities, health, and religious or moral beliefs and stating the facts and circumstances that demonstrate such familiarity." § 527.10(c)(3).

any potential surrogate bars the research, nor do they even require that others on the list at least be informed of the proposed research. Moreover, the regulations are devoid of any criteria -- including such a fundamental concept as the patient's wishes -- to be used by the surrogate in making a research decision. Thus, surrogates can, and do, consent to placing institutionalized patients with mental illnesses in research projects of greater than minimal risk with no prospect of direct benefit to the patient.

The lower court invalidated the challenged regulations on the ground that OMH was not authorized to make rules for research involving human subjects -- a task which the legislature specifically reserved for the Commissioner of Health. R. 38. In doing so, the lower court embraced the stated purpose of the Public Health Law as properly governing human subject research:

> Every human being has the right to be protected against the possible conduct of medical or psychological research upon his body without his voluntary informed consent. Human research may effect dangerous and unanticipated results causing irreversible damage to the human subject. Accordingly, it shall be the policy of the state to protect its people against the unnecessary and improper risk of pain, suffering or injury resulting from human research conducted without their knowledge or consent. R. 34 (quoting Public Health Law § 2440).

Plaintiffs seek affirmance of the lower court's judgment, and also cross-appealed seeking injunctive relief. As is fully discussed in Plaintiffs/Respondents' brief, the OMH regulations, in addition to being wrongly promulgated, violate basic constitutional and common law principles. Therefore, Plaintiffs

seek to enjoin, inter alia, (1) non-therapeutic research of greater than minimal risk on (a) adults who are incapable of consent and who have not previously executed an advance directive, or (b) children for whom consent was provided by a surrogate; (2) therapeutic research of greater than minimal risk on incapable adults without prior court determination that (a) the patient is incapable of consenting, (b) the experiment directly benefits the patient, and (c) the experiment is in the best interest of the patient, weighing the benefits, adverse side effects and the availability of less intrusive treatments. R. 10.

Defendants frame the issue as one of individual autonomy and liberty versus the state's interest in the preservation and general enhancement of human life. Brief of Defendants/Appellants at 51. Amici supporting Defendants, The New York State Psychiatric Association, Inc. and the American Academy of Child and Adolescent Psychiatry, attempt to paint the issue as a conflict between progress in the understanding and cure of major illnesses, namely Alzheimer's disease and AIDS, and the rights of individual institutionalized patients. Brief of Amici at 9.[6] Out of misplaced concern for the continued flow of research dollars, Defendants and Amici have conjured a conflict which does not exist.

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[6] Amicus Associated Medical Schools of New York (Brief at 13) merely frames the issue as one of judicial deference to administrative action.

The real issue beneath the lofty language in Defendants/Amicis' briefs is whether the rights of individual institutionalized patients can be sacrificed for the postulated greater good of society, particularly where, as here, both interests can be readily reconciled. More concretely, the question for the Court is whether researchers may subject an institutionalized patient -- who had not previously expressed his views on participation in experiments, and is currently incapable of giving consent -- to high-risk research that holds out no prospect of any direct benefit to that patient, based solely on the consent of a surrogate who is not required to consider what the patient would have wanted or what is in the patient's best interest. That such a regulatory scheme is morally and legally unacceptable is underscored by the fact that it is in no way necessary to achieve the research goals which Defendants/Amici support. These goals can be achieved by the use of advance directives, which permit individuals to document their wishes as to certain kinds of treatment or research participation at a time when they are still capable of doing so. As the court below recognized, and as discussed in Section II, infra, patients with AIDS or Alzheimer's disease are capable of consenting to research long in advance of the final stages of the illnesses that eventually render them incapable (see, e.g., Opinion of Judge Greenfield, Feb. 28, 1995 ("Op.") at n.3, R. 27), and most others diagnosed with mental illnesses have periods of lucidity when

they are also capable of consenting to non-therapeutic research. R. 2876 (Stastny Affidavit).

Section II of this brief also recounts the history of abuses of human subjects in medical research and experimentation, and the steps taken by the medical community itself to prevent non-therapeutic, high-risk research on incapable subjects. This history aptly illustrates the conflicts inherent in the role of a researcher, conflicts which the OMH regulations do not sufficiently address.

Section III discusses the laws and regulations of many other states with restrictions on research more stringent than those adopted by OMH, further highlighting the inadequacies of the OMH regulations at issue here. Moreover, the experiences of these states demonstrate that progress in the understanding and cure of mental illness will not grind to a halt by adhering to the principles of informed consent required by the constitution and common law.

II. The History Of Research Abuses And Development Of The Law Of Informed Consent Underscore The Deficiencies Of The OMH Regulations

It is undisputed in this litigation and in American jurisprudence that a person of sound mind has the right to determine what will be done to his or her own body. Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.). The question in this case is what a researcher and/or surrogate can do to the body of someone

incapable of consent who has never explicitly expressed views on participation in experimental research.

With regard to non-therapeutic research of substantial risk, it is fundamental that "[o]ne is not obliged to do a small good to society at the expense of great harm to oneself." David Hume, Essay on Suicide, in Moral Problems in Medicine (Samuel Gorvitz et al. eds., 1976). Yet that is precisely what the OMH regulations permit someone else to decide for the institutionalized patient. The regulations allow the researcher to pervade every aspect of the process for obtaining consent, and then perform experiments of substantial risk on a subject without his knowledge. The researcher, alone, may determine whether a potential subject is incapable of consenting. R. 2635. After deciding that a person is incapable, the researcher may choose not to inform the subject that he will be participating in non-therapeutic research of greater than minimal risk. The researcher may then "forum shop" amongst potential surrogates in order to find one who will consent, regardless of whether others would object. § 527.10(e)(2)(iv). (See discussion, supra).[7] The researcher is also authorized to obtain consent from the surrogate, who is not bound by either the patient's subjective

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[7] Forum shopping is not just a hypothetical concern. In a review of research studies of schizophrenic patients, Candilis noted that psychiatric researchers bypassed the next of kin when they anticipated objection to the proposed research. P. Candilis et al., A Survey of Researchers Using a Consent Policy for Cognitively Impaired Human Research Subjects, 15 Institutional Rev. Bd. 1-5 (1993).

wishes or by an objective assessment of the patient's best interest. § 527.10(e)(2)(iv).

The influence accorded a researcher over the consent process permits the researcher and the surrogate to enlist a patient in non-therapeutic research in a manner contrary to the patient's wishes and to established New York law. As evidenced by the position of Defendants and its amici in this litigation, some researchers will make a fundamental ethical choice for a subject not permitted by American constitutional and common law: They argue that an individual's civil liberties can be sacrificed in favor of society's interest in advancing research, even when the individual would not make that choice for himself, stands to gain nothing from that risky decision and the research poses a real risk of harm to that individual. The history of research abuse demonstrates that no surrogate should ever be permitted to place an incapable institutionalized person in non-therapeutic research, absent clear and convincing evidence of the patient's desire to participate in such research, as expressed by the patient at a time when he or she was capable of consent. Similarly, patients should not be deemed incapable and enrolled in therapeutic research of greater than minimal risk without procedures that take into account the researcher's inherent conflict of interest, which impairs his ability to assess a subject's capacity and best interest. New York jurisprudence embraces the lessons to be learned from this history, and is contrary to Defendants' position. Rivers v. Katz, 67 N.Y.2d 485,

504 N.Y.S.2d 74 (1986). See also Brief of Plaintiffs/Respondents.

A. Abuse Of Human Research Subjects Is A Present -- Not A Past -- Problem

History teaches that researchers face inherent conflicts between their role as investigators and their role as treating physicians, and frequently elevate the goal of medical progress above concerns for the best interest of the subject. Incidents of disregard for the principles of informed consent in biomedical research are, unfortunately, not confined to the distant past. Such recurring incidents demonstrate that the need for strict regulation of consent procedures in research settings is as great as it ever was.

Recent examples illustrate startling failures by investigators to impart basic information about the nature and risks of research to their subjects. In June of this year, the U.S. Centers for Disease Control ("CDC") admitted that, in a CDC-sponsored study of two measles vaccines conducted on nearly 1,500 infants between 1989 and 1991, parents were not informed that one of the vaccines was experimental and had not been licensed for use in the United States.[8] And in March of this year, a federal district court certified a class of pregnant women who, since November 1986, were placed in research projects in which drugs were administered to fetuses at risk of premature delivery to determine whether the drugs would hasten lung development. Diaz

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[8] Marlene Cimons, U.S. Measles Experiment Failed to Disclose Risk, Wash. Post, June 17, 1996, at A8.

v. Hillsborough County Hosp. Auth., 165 F.R.D. 689 (M.D. Fla. 1996). The drugs were administered by way of amniocentesis, a procedure carrying a risk of spontaneous abortion, stillbirth, or premature delivery.[9] The National Institutes of Health ("NIH") found in April 1991 that the hospital could not prove that complex consent forms were adequately explained to the pregnant patients. Id.

In a study at the Neuropsychiatric Institute of the University of California, Los Angeles ("UCLA"), conducted between 1988 and 1994, schizophrenic patients whose psychosis had been controlled with medication were suddenly withdrawn from that medication in the expectation that a relapse (recurrence of symptomatology) in many patient-subjects would result.[10] The object of the study was to improve prediction of relapse, particularly of those who would exhibit "bizarre behavior, self-neglect, hostility, depressive mood and suicidability." Id. at 41-42 (quoting the research protocol). The consent form did not reveal, however, that those particular symptoms were almost 90 percent likely to recur upon sudden withdrawal of the medication. Id. at 46.[11] To the contrary, the consent form promised that

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9 Cathy Cummins, Pregnancy Suit's Scope Still to be Determined, Tampa Trib., March 29, 1996, at 1.

10 Jay Katz, Human Experimentation and Human Rights, 38 St. Louis U. L.J. 7, 41-51 (1993).

11 The UCLA incident is but one example of how a double-blind, controlled experiment is inconsistent with appropriate medical treatment for its subjects. Research proceeds according to a detailed and largely inflexible protocol, while clinical practice, or therapy, depends on

subjects would receive "regular care," without making clear that withdrawal of medication would probably undermine their care. Id. at 44-45. In 1994, NIH reprimanded the scientists in charge of the study for failing to obtain proper consent from patients before withdrawing the medication.[12]

These recent examples are not rare aberrations, but rather are representative of a pervasive problem. As one prominent researcher noted, "[t]he UCLA case reported in the lay press is not an isolated example, but an indication of possible serious and widespread lapses in the protection of vulnerable patients." Adil Shamoo and Timothy Keay, Ethical Concerns About Relapse Studies, 5 Cambridge Quarterly of Healthcare Ethics 373, 383 (1996). See also Katz (1993), supra, at 50-51. In an analysis of drug research projects between 1980 and 1995, the General Accounting Office discovered 84 deficiency citations in the records of the Food and Drug Administration ("FDA"), including citations for inadequate and forged informed consent forms; failure to inform subjects that drugs were experimental; failure to report adverse reactions to drugs under study, including a

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highly individualized and nuanced, even ad hoc, dosage adjustments and changes in therapeutic modalities. Robert J. Levine, Informed Consent in Research and Practice, 143 Archives of Internal Med. 1229, 1231 (1982). Thus, the inflexibility required by scientific inquiry can harm the welfare of the patient requiring individualized care. In short, what the OMH regulations refer to as "non-therapeutic research" can often be anti-therapeutic -- heightening the need in such cases for procedures that will ensure a truly informed consent.

[12] Philip J. Hilts, Agency Faults a UCLA Study for Suffering of Mental Patients, N.Y. Times, Mar. 10, 1994, at A1.

patient's death; and proceeding with a cancer study after it had been suspended by the FDA. See Sarah F. Jaggar, GAO, Scientific Research - Continued Vigilance Critical to Protecting Human Subjects (Mar. 12, 1996) at 13-14. In a separate analysis of persons disciplined for scientific misconduct, investigators reviewed FDA files of clinical trials between 1975 and 1983. The investigators discovered that 44 percent of those disciplined had failed to obtain informed consent; 59 percent falsified data and 37 percent failed to obtain IRB approval for the study. Martin F. Shapiro & Robert P. Charrow, Scientific Misconduct in Investigational Drug Trials, 312 N. Engl. J. Med. 731, 734 (1985).

As these recent examples demonstrate, failure to obtain informed consent from subjects of biomedical research is a present and persistent problem. The need for adequate regulation is great because the individuals affected by the challenged aspects of the OMH regulations are among the most vulnerable members of society -- adults and children with psychiatric or cognitive impairments who are committed to mental hospitals and who have been (or will be) deemed incapable of giving informed consent.

B. Researchers Face Inherent Conflicts That Impair Their Ability To Ensure That Consent Is Informed And Meaningful

Researchers constantly face a conflict between obtaining fully informed consent from research subjects -- a difficult task under any circumstances -- and advancing their research and

scientific progress by persuading potential subjects to agree to participate. Researchers have a tendency to minimize the risks of their own projects, inadvertently downplaying the potential individual harm that can result when the long-term benefits to society may be great. See, e.g., David J. Rothman, Strangers at the Bedside 56-81 (1991). Indeed, the American Psychological Association has recognized that personal involvement of the researcher in the consent process may lead to exaggeration of the scientific merit of the proposed research and underestimation of the costs to the research participant. Ethical Principles in the Conduct of Research with Human Participants (1982) at 20. A researcher's ultimate goal is to produce medical information beneficial to future patients, such as a cure for AIDS or Alzheimer's.[13] The researcher may also be motivated by an interest in improving his professional reputation and research support. Schneyer, supra, at 160; American Psychological Association, supra, at 28. These are not improper goals, but they may conflict with a subject's wishes or best interest -- a conflict which the researcher, because of his different focus, may fail to recognize.

Moreover, researchers often have difficulty switching to the role of investigator, whose paramount interest is the research project, rather than the condition of the subject, and continue to see themselves in the role of doctor treating a patient.

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[13] Schneyer, Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices, 1976 Wis. L. Rev. 124, 160.

Thus, researchers sometimes withhold information they perceive might disturb or harm the subject, and substitute their judgment for that of the subject's, as if they were treating a patient rather than objectively informing the subject of potential hazards of proposed research. As a result, researchers may fail to provide a potential subject with information necessary to assess the risks of an experiment. See, e.g., Rothman, supra, at 56-81. This confusion more frequently occurs in cases such as this, where the subjects are institutionalized and likely to assume that the physician is treating them; researchers in these circumstances similarly tend to approach the subject from the perspective of a treating physician. Id. at 63.

One method for ensuring truly informed consent is to remove researchers from any role in determining incapacity, choosing surrogates from whom to seek consent, and obtaining the subject's consent -- all functions which the OMH regulations permit the researcher to perform.

The dangers posed by the investigator's conflict of interest are illustrated by the Tuskegee Syphilis Study.[14] Over a span

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[14] Ruth R. Faden & Tom L. Beauchamp, A History and Theory of Informed Consent 165-67 (1986).

The examples discussed in this brief are only the most infamous of countless examples that could be discussed. A 1966 article by Henry K. Beecher collected 50 cases of research exhibiting ethical violations, in only two of which was it even mentioned that the consent of subjects had been obtained, and in several of which vulnerable or disadvantaged subjects were simply unaware of their participation in research. Henry K. Beecher, Ethics and Clinical Research, 274 New Eng. J. Med. 1354 (1966). In a book published the next year, a different author revealed some 500 academic papers

of 40 years ending in the 1970s, approximately 400 black males with syphilis participating in a study conducted by the Public Health Service were not given available treatments for syphilis so that investigators could determine the long-term health effects of the disease. The participants were not told that they had syphilis or that they were participating in a non-therapeutic experiment. Even worse, the Public Health Service requested that the Army not treat the subjects drafted into serving their country during World War II. At least 28 and as many as 100 of the men died of syphilis, and others developed serious syphilis-related heart conditions. James H. Jones, Bad Blood 1-2 (1981).

The case of the Jewish Chronic Disease Hospital is further evidence that physician-investigators' confusion about their role can result in a sacrifice of patient autonomy.[15] In 1963, a physician at the Sloan-Kettering Institute for Cancer Research in New York, Dr. Chester M. Southam, persuaded hospital medical director Emmanuel E. Mandel to involve hospital patients in a study without the patients' consent. Live cancer cells were injected into patients who were never told the contents of the injections.[16] The injections offered no therapeutic benefit to

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involving unethical experiments. M.H. Pappworth, Human Guinea Pigs (1967).

[15] The account of this incident is taken from Faden & Beauchamp, supra, at 161-62, and documents compiled in Jay Katz, Experimentation With Human Beings 9-65 (1972).

[16] The physician-researchers maintained that, because the cells were foreign, the patients would inevitably reject them, and there would be no risk that they would develop cancer. Other physicians who objected to the research

the patients. The physicians' view was that "they can go ahead and do anything which they conclude is good for the patient, or which is of benefit experimentally or educationally and is not harmful to the patient, and that the patient's consent is an empty formality." Opinion of the Board of Regents' Discipline Committee, reported in Katz (1972), supra, at 60.[17]

Part of the problem stemmed from the fact that Drs. Southam and Mandel confused their roles as researchers with their roles as treating physicians. They defended the absence of informed consent on the grounds that they were acting as physicians in declining to provide patients information that would disturb and therefore harm them. The Discipline Committee rejected this defense:

> They [Drs. Southam and Mandel] overlooked the key fact that so far as this particular experiment was concerned, there was not the usual doctor-patient relationship and, therefore, no basis for the exercise of their usual professional judgment applicable to patient care.

Id. at 61. The Regents recognized that the roles of the physician and the researcher are fundamentally different and make

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suggested that there was, in fact, a risk that patients would develop cancer from the injection or that patients who already had cancer and received the injection would experience a worsening of their existing cancer because their immune systems would be taxed by the injection. Id. at 49, 60.

[17] Each physician received a sentence of suspension from practice, which was stayed in each case in favor of probation.

for a dangerous mix in connection with a non-therapeutic research study.

That dangerous mix proved fatal to one institutionalized patient in an OMH institution. In 1952, a patient voluntarily admitted himself to Defendants' New York State Psychiatric Institute. Without being told that he was being injected with a mescaline derivative provided by the Army Chemical Corps to determine its suitability as a chemical warfare agent (he believed the injections were therapeutic), he agreed for a time to the injections. Barrett v. United States, 660 F. Supp. 1291 (S.D.N.Y. 1987). Before the fourth injection, he objected but was told by his therapist that if he did not continue with the experiment he would be returned to institutions where he had been very unhappy. Id. at 1300. The fifth injection caused Barrett's death. The Army hid its role in the experiments for over 20 years, and OMH contested its own liability. Id. See also GAO, Department of Energy: Information on DOE's Human Tissue Analysis Work 18 (June 19, 1995) (subjects injected with plutonium without their knowledge between 1945 and 1947 to study the effect of plutonium on humans); Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973) (prisoner administered paralyzing "fright drug" without his consent in experiment to determine whether instilling fright and inflicting pain would affect behavior).

C. Surrogate Consent Often Disregards The Subject's Intent Or Best Interest

History also teaches that surrogate decisionmakers cannot always be relied on to protect the interests of the subject. The Willowbrook State School case illustrates the susceptibility of surrogates to improper pressures when the surrogate is not required to employ any particular criteria in consenting to another's participation in research. Faden & Beauchamp, supra, at 163-67.

The population of Willowbrook consisted of children with retardation, most of them with severe conditions. The director noted that within six to twelve months of admission, all susceptible children contracted hepatitis, and he began a series of experiments in 1956 to develop a prophylactic agent. The staff deliberately infected with the hepatitis virus new patients whose parents consented in writing. As with the recent examples discussed supra, the consent procedures were inadequate to inform parents of the true nature and risks of the research, or alternatives thereto. In fact, the consent form indicated that the children would receive a vaccine against the virus. Id. at 167. Moreover, the institution coerced parents into providing consent after 1964 by refusing new patients unless their parents consented to the child's participation in the hepatitis study. Paul Ramsey, The Patient as Person: Explorations in Medical Ethics 54 (1970).

Surrogates may also assume, correctly or incorrectly, that their wards will receive better treatment or special privileges

at the institution if they participate in desired research. For example, in the 1940s and 1950s, scientists from the Massachusetts Institute of Technology exposed children, some of whom had mental impairments, to radioactive iron or calcium. Letters seeking permission from parents or guardians of potential subjects did not mention the use of a radioisotope, and implied that subjects would benefit nutritionally. The letters also offered additional privileges, including extra milk and additional outings.[18]

Without appropriate guidelines, surrogates may also be influenced, however subconsciously, by such improper considerations as the perception that the patient's continued care is dependent on participation in research, or desperation for a cure even when the research is non-therapeutic.[19]

Investigators have discovered, in the process of recruiting subjects with psychiatric impairments for research projects, "a pattern of family control that discounts the patient's wishes in

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[18] Final Report, Advisory Committee on Human Radiation Experiments, 342-47 (1995).

[19] The American College of Physicians recognizes that surrogates concerned about the welfare of institutionalized patients may be influenced by the fear that refusing research might prejudice the patient's care. Surrogates may also be susceptible to positive inducements to consent, such as better living quarters. American College of Physicians, Cognitively Impaired Subjects, 110 Annals of Internal Med. 843, 846 (1989). See also Barbara A. Weiner, Rights of Institutionalized Persons, in Mentally Disabled and the Law 293 (1985).

the decision-making process."[20] One study has shown that over one-third of surrogate decisionmakers consented to their relative's participation in research despite believing that their relative, if competent, would not have wanted to participate.[21] Other recent studies also show significant discord between the choices of patients/subjects and their proxies.[22]

It is far easier to decide that someone else should sacrifice for medical advances -- particularly someone who is suffering from dementia or other mental illness -- than to make that choice for oneself. See supra notes 20-22. As Henry Beecher, the author of a landmark article on research abuses, noted:

> Ordinary patients will not knowingly risk their health or their life for the sake of "science." Every experienced clinician knows this. When such risks are

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20 Ketai et al., supra, at 351-53. The authors discovered "striking manipulation" by family members to effect the participation of their schizophrenic relatives in high-risk research. Id. at 351. The authors noted that "[t]his behavior is consistent with previous reports of family members compromising the autonomy of patients with schizophrenia." Id. at 352-53 (citing six studies).

21 J.W. Warren et al., Informed Consent by Proxy: An Issue in Research with Elderly Patients, 315 New Engl. J. Med. 1124-28 (1986) (the study was one of minimal risk). Moreover, twenty-one percent of those surveyed were persons who would not have consented on their own behalf, but provided consent on behalf of their relative.

22 Nancy R. Zweibel and Christine K. Cassel, Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies, 29 Gerontologist 615-21 (1989) (of those surveyed, the patient wanted the proxy to make the opposite treatment decision in 24 percent to 50 percent of the hypotheticals put to them; the patient's burden on the family was one of the top criteria for the proxy's decisions).

> taken and a considerable number of patients are involved, it may be assumed that informed consent has not been obtained in all cases. . . . I have worked on the ward of a large hospital for 35 years, [and] I know perfectly well that ward patients will not . . . volunteer for any such use of themselves for experimental purposes when the hazard may be permanent injury or death.

(quoted in Rothman, supra, at 75). The decision to perform a social good by participating in non-therapeutic research of significant risk is a choice that no surrogate can legitimately make for another person, absent clear evidence of the subject's wishes. This is particularly true when dealing with institutionalized patients -- one of the most vulnerable segments of society, and a group which bears a disproportionate amount of the research burden.[23]

Moreover, the surrogate decisionmaker is subject to the same misconception of the role of the physician-investigator as is the physician-investigator himself. Just as researchers often perceive themselves as care-giving physicians, even when engaged

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[23] The American Medical Association has determined that institutionalized patients are disproportionately used in research studies and has, in its Code of Medical Ethics, required that physicians refrain from offering incentives to their participation in research: "The overuse of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participant is subjected to powerful incentives and persuasion." American College of Physicians, Code of Medical Ethics, in Codes of Professional Responsibility 237, 276 (Rena A. Gorlin ed. 3d ed. 1994). See also, Final Report, supra, at 785 (in many biomedical experiments between 1944 to 1974 reviewed by the Commission on Human Radiation Experiments, researchers drew from relatively powerless, easily exploited groups including hospitalized adults and institutionalized children).

in research, so too do others misconceive the role of the researcher, and are predisposed to view the research as serving the therapeutic interest of the subjects.[24] This tendency undermines the ability of the surrogate to evaluate objectively the nature and risks of the research.

The New York Legislature specifically recognized this troubling history in enacting Article 24-A of the Public Health Law, citing the Jewish Chronic Disease Hospital study, the Willowbrook experiment on children, the Tuskegee syphilis study and Beecher's article recounting numerous examples of research abuses. It was the purpose of that legislation to prevent a recurrence of such abuse. Governor's Bill Jacket, 1975, Chapter 450. This Court should not permit that legislative purpose to be thwarted by the OMH regulations at issue here.

Other physicians and legislators agree that risky, non-therapeutic research should never be performed on incapable patients whose wishes are unknown. Paul Ramsey, supra, at 14 (research should never involve incompetent persons if it does not hold out the prospect of direct benefit to the individuals on whom the research is conducted) (the book is based on the Lyman Beecher Lectures that Ramsey delivered at the Divinity School and the School of Medicine of Yale University). The British Medical

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[24] Michael Bamberg & Nancy Budwig, Therapeutic Misconceptions: When the Voices of Caring and Research are Misconstrued as the Voice of Caring, 2 Ethics and Behavior 165-84 (1992); Final Report, supra, at 761.

Research Council[25] takes the same view: "when true consent cannot be obtained, procedures which are of no direct benefit and which might carry a risk of harm to the subject should not be undertaken." I.G. Pryce, Clinical Research Upon Mentally Ill Subjects Who Cannot Give Informed Consent, 132 Brit. J. Psychiatry 366, 366 (1978). Surrogate consent is only permitted in the United Kingdom for experimental procedures leading to a possible benefit to the patient. Id.

Legal and political bodies have come to a similar conclusion on this issue. For example, the American Bar Association's Commission on the Mentally Disabled (now known as the Commission on Mental and Physical Disability Law) has taken the position that non-therapeutic research on institutionalized persons with mental disabilities should involve no more than minimal risk to the health or well-being of the subject. "Irreversible effects are not 'minimal.'" Statement of ABA Commission on the Mentally Disabled Before National Human Experimentation Group, 1 Mental Disability L. Rep. 155, 156 (1976). The International Covenant on Civil and Political Rights prohibits any medical or scientific experimentation that may be detrimental to the health of anyone

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[25] The UK Medical Research Council, established in 1913, is funded mainly by the government of the United Kingdom. It has created its own research institutes, including the National Institute for Medical Research (which includes Applied Psychology and Child Psychiatry Units and Initiatives for AIDS and HIV), that are responsible for numerous, dramatic advances in research: discovery of a method of production of artificial hemoglobin in 1992, discovery of the gene for Huntington's disease in 1993, and discovery of a drug therapy for AIDS sufferers in 1995. MRC Home Page.

involuntarily detained in psychiatric hospitals. The Nuremberg Code, adopted in 1947 by the multi-national tribunal sitting in judgment on the Nazi's atrocities, prohibits any biomedical research on subjects who are not competent. Katz (1972), supra, at 305.

As underscored by these studies and the analysis of several medical and legal organizations, surrogates should not be permitted to make choices for incapable patients without any criteria to guide that decision. Nor should the researcher be able to choose selectively from a long list of potential surrogates. These shortcomings in the OMH regulations, combined with the pervasive influence they accord the researcher over the consent process, encourage the same abuses that have been inflicted on human research subjects -- including the elderly, persons with mental illness and children -- for decades.

D. The Right To Object Afforded By The OMH Regulations Does Not Adequately Protect Incapable Research Subjects

In the case of non-therapeutic research on adults and children undertaken with surrogate consent, Defendants argue that the subject's interests are adequately protected by the subject's right to object and withdraw from the project. Def. Brief at 49-50. The fallacy of this argument is immediately apparent. Defendants ignore the fact that the regulations do not require that incapable subjects ever be informed that someone else has consented to their participation in research, or that the "treatment" they are receiving is part of a research project rather than their normal treatment plan.

Defendants' argument also ignores the fact that the research at issue is being conducted on individuals who have already been deemed "incapable" of consenting. They are thus individuals who lack the "ability to understand the purpose, nature, risks, benefits and alternatives (including non-participation) of the research." § 527.10(c)(2). These individuals, relying on their physicians to make decisions for their health and welfare, reasonably assume that the research is for their benefit, and have no reason to object. Bamberg & Budwig, supra. Even if they want to object, they may be unable or unwilling to do so, for fear of repercussions. Indeed, since the definition of "capacity" also requires an ability to "understand that the decision about participation in the research will involve no penalty or loss of benefits to which the patient is otherwise entitled," § 527.10(c)(2), many individuals who lack "capacity" will, by definition, be unable to comprehend that their objection would carry no penalty, and will thus be unable or unwilling to express their objection.

E. Use Of Advance Directives And Court Approval Would Protect Patient Rights Without Threatening Legitimate Research

1. Advance Directives For Research

As the preceding sections demonstrate, researchers and surrogates often act, despite noble purposes and good intentions, without careful consideration of the potential subject's preferences or best interest. The use of advance directives -- documents that are executed by persons while capable of

consenting, and that outline the parameters of their willingness to participate in research -- would address the problems inherent in permitting researchers to obtain surrogate consent without objective criteria as guidance. Indeed, many sectors of the medical community have endorsed this approach, and have disapproved surrogate consent to non-therapeutic research of greater than minimal risk on patients who are incapable of consenting.

Defendants and its Amici cry wolf when they suggest that society will not be able to cure serious diseases, such as AIDS and Alzheimer's, without surrogate consent to the use of institutionalized subjects. Similarly dire warnings have issued each time, over the last 50 years, that additional research restrictions have been imposed to protect the rights of subjects -- yet research funds and techniques continue to advance. Defendants and Amici have not identified any group of essential research subjects who would be incapable, at some point, of providing an advance directive specifying their views on participating in research. Moreover, many states, as well as the United Kingdom, have for years imposed restrictions on the types of research that can be performed with incapable subjects, and restrictions on surrogate consent to that research, yet there has been no outcry about the downfall of scientific progress. See Section III, infra. It is indeed odd for Defendants to suggest that Plaintiffs (themselves diagnosed with mental illness), or the undersigned (devoted to the rights and interests of such

individuals),[26] are somehow enemies of medical progress to cure mental illness. Plaintiffs and the undersigned seek only to ensure that the cause of scientific progress is not used as a weapon to trample the rights of individuals with mental illness -- particularly where, as here, the two interests can be so readily reconciled.

It makes no sense to suggest, as Defendants and their Amici do, that progress in finding the cures for AIDS and Alzheimer's disease will grind to a halt without the ability to obtain surrogate consent to use incapable subjects in non-therapeutic research. Brief of Amici at 6. As earlier noted (see supra note 25), the UK National Institute for Medical Research has made several recent significant research advances, despite a complete bar on non-therapeutic research on individuals incapable of giving informed consent. Indeed, the use of advance directives, advocated here, will provide ample latitude for continued research on mental and other illness. As the Chair of the IRB for the National Institutes of Mental Health ("NIMH") has explained, patients diagnosed with Alzheimer's typically learn of their disease long before they are rendered incapable, and are thus "classic examples" of individuals for whom advance directives are ideally suited. Trey Sunderland and Ruth Dukoff, Informed Consent with Cognitively Impaired Patients: An NIMH

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[26] See Affirmation in Support of Motion for Leave to Appear as Amici Curiae (Appendix hereto) for a description of amici, many of whom advocate research into the causes/cures of mental disabilities and AIDS.

Perspective on the Durable Power of Attorney, 4 Accountability in Research 217, 224-25 (1996). Individuals diagnosed with Alzheimer's and AIDS can execute a written directive while they are still capable of giving informed consent, indicating their willingness to participate in research that will begin when they are no longer capable. See Op. at n.3, R. 27; R. 2875-77 (Stastny Affidavit). In addition, most people with chronic mental illnesses experience periods of remission from their illnesses; consent to research can thus readily be obtained from these patients when their illnesses are in remission. R. 2876.

The National Institutes of Health ("NIH") has successfully used advance directives since 1985 to obtain consent for participation in research projects from proposed subjects. Sunderland and Dukoff, supra, at 221. Even after their illnesses render the subjects incapable, their continued assent to research is solicited, and any objection by the subject is honored. Id. at 223-24. Such use of advance directives has not hindered NIH research into Alzheimer's or other dementia-related illnesses. In 1976, prior to the use of advance directives, the budget for the NIH's National Institute on Aging ("NIA") was $19.2 million. Evan DeRenzo, Surrogate Decision Making for Severely Cognitively Impaired Research Subjects: The Continuing Debate, 3 Cambridge Quarterly of Healthcare Ethics 539 (1994). By 1986, just after advance directives were first employed, the budget was $150.9 million. Id. Eight years into the use of advance directives, NIA received $420 million, with half of those funds designated

for Alzheimer's research and other dementia-related conditions. Two other NIH agencies received an additional $75 million that year for similar research. Id. By 1996, NIA was budgeted to receive $451 million. Budget of the United States Government, Fiscal Year 1996, Appendix at 476.

Defendants' only argument against the use of advance directives is that OMH cannot always predict in advance what subjects will be suitable for future research projects. Def. Brief at 40. While that may be true, it is not an argument against the use of advance directives, but rather an argument for obtaining them from all patients willing to execute such directives, so that their research wishes will be known and respected. Defendants cannot justify the surrogate shopping and unfettered discretion accorded to surrogates, permitted by the OMH regulations, when potential research subjects could be asked to state their wishes at a time when they are capable of providing informed consent.

A number of groups within the medical community have also rejected Defendants' position, and advocate the use of advance directives. The American College of Physicians takes the position that, in the absence of an advance directive, surrogates should not be permitted to consent on behalf of cognitively impaired subjects to non-therapeutic research that presents more than a minimal risk of harm or discomfort. American College of Physicians, Cognitively Impaired Subjects, 111 Annals of Internal Med., 843, 844 (1989). Moreover, the College believes that, in

the absence of a clear directive from the patient, surrogates should always be governed by what is in the incompetent person's best interest. Id. at 845. Following these guidelines will protect the needs of both the patient and the research community -- it "will allow progress in research without violating society's obligation to uphold the rights and protect the welfare of potential experimental subjects." Id. at 843.

Other physicians and legal analysts in the United States and abroad agree. See Zweibel (Director of Research and Geriatrics and Gerontology, University of Chicago Department of Medicine) and Cassel (Chief of Section of General Internal Medicine, University of Chicago Department of Medicine), supra, at 620 ("The findings [on surrogate decisionmaking] support the importance of advance directives as necessary for ensuring patient autonomy . . . ."); G.J. Annas, J.D., M.P.H., L.H. Glantz, J.D. (Boston University Schools of Medicine and Public Health), Rules for Research in Nursing Homes, 315 N. Engl. J. Med. 1157 (1986) (research with incompetent subjects should be related to a problem unique to this population and should involve either no or minimal risk; surrogates should never volunteer another for non-therapeutic experimentation that carries any risk of harm absent specific prior instructions from the subject).

Thus, the relief sought by Plaintiffs is neither new nor radical. Both the medical and legal communities recognize that substantial safeguards are necessary to protect institutionalized persons with mental illness, who are disproportionately used in

the conduct of experimental research. Such safeguards, they realize, include a prohibition on the conduct of non-therapeutic research on institutionalized patients with mental illnesses in the absence of a prior express indication of their wishes. Moreover, even if, as Defendants and Amici suggest, the progress of science is more measured as a result of more stringent regulation -- a proposition contrary to the weight of the evidence -- that is a price we must pay. Society cannot choose "martyrs for science" from a select class of its most vulnerable citizens. Hans Jonas, Philosophical Reflections on Experimenting with Human Subjects, 98 Daedalus 219, 222, 245 (1969); Katz (Professor of Law, Medicine and Psychiatry, Yale Law School) (1993), supra, at 30. In essence, society cannot choose to make human guinea pigs of our most vulnerable citizens.

2. Therapeutic Research On Incapable Patients Of Greater Than Minimal Risk Requires Court Approval

All six plaintiffs in this case were ordered to submit to risky, but non-experimental, medical treatment (either electroshock therapy or psychotropic medications) over their objection, only after a court hearing. Nothing less is permitted under the New York constitution, common law and statutory law to require incapable subjects to participate in therapeutic research of greater than minimal risk. N.Y. Mental Hygiene Law § 81-21

(McKinney 1996)[27]; Rivers, 67 N.Y.2d 485, 504 N.Y.S. 2d 74; Brief of Plaintiffs/Respondents.[28]

The same risk of abuse is clearly present under the OMH regulations with regard to therapeutic as with non-therapeutic research. The researcher can make the determination of incapability and shop for consent from a surrogate with no guidance for weighing the risks and benefits, and no requirement for abiding by the patient's wishes or best interest. The regulations therefore violate New York law in this respect as well, since established precedent requires a court to make these determinations.[29] Many other states also require court approval for high-risk, therapeutic research. See Section III.B, infra.

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[27] This statute provides that a court may grant a guardian authority to make treatment decisions consistent with, inter alia, the patient's wishes, the patient's best interests if his or her wishes cannot be ascertained with reasonable diligence, and any less intrusive alternative treatments. § 81.22(8).

[28] It is thus hard to imagine how Defendants can maintain that risky non-therapeutic research -- with no prospect of benefit to the patient -- can be imposed with even fewer protections, as the OMH regulations allow. See discussion supra.

[29] The undersigned proposed amici do not suggest that court approval must precede enrollment of capable individuals in possibly therapeutic research.

III. Many Other States Employ Procedures For Obtaining Informed Consent More Restrictive Than The OMH Regulations, And Research Nonetheless Thrives

A. Many States Prohibit Non-Therapeutic Research On Subjects Incapable Of Providing Informed Consent

Many states have legislation or regulations prohibiting non-therapeutic research on subjects incapable of consent. Yet despite the more restrictive elements of these regulations, amici are unaware of any complaints about resulting or notable declines in essential research into mental illness that requires the use of incapable subjects. In fact, several states with the greatest restrictions on research, and which ban all non-therapeutic research of greater than minimal risk on subjects who have been deemed incapable of consent, receive some of the largest grants from the National Institutes of Mental Health ("NIMH") for research. California, which only permits a conservator's consent for treatment based on medical advice when necessary, infra, received the highest grant from NIMH in 1995, in the amount of $80 million. NIMH Research Information Sourcebook -- Extramural Research (1995). Massachusetts, Illinois and Connecticut, which similarly restrict research on incapable subjects (see infra), ranked fourth, seventh and eighth, respectively, in the size of their NIMH grants in 1995 ($26.6 million, $14 million and $13 million, respectively). Id. These states have been similarly ranked in the size of their research grants from NIMH since 1986. Id. (reports from 1986 to 1995).

A review of these statutory and regulatory schemes illustrates the deficiencies of the OMH regulations in failing to

protect persons with mental disabilities. See, e.g., Alaska Stat. § 13.26.150 (1995 Supp.) (a guardian may not consent to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward); Alaska Stat. § 47.30.830(a) (1995) ("Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient"); Cal. Prob. Code § 2354 (West 1991) (conservator of subject incapable of giving consent may seek treatment only in good faith based on medical advice when necessary); Conn. Gen. Stat. Ann. § 45a-677 (West Supp. 1993) (limited guardian, who may be assigned by court to consent to medical care for persons with mental disabilities, may only consent to experimental biomedical experiment or procedure if intended to preserve life, prevent serious physical impairment or assist in regaining ward's abilities); Del. Code Ann. tit. 16, § 5172(b)(1)-(2) (1995) (no patient may be approached to participate in pharmaceutical research if incapable of voluntary consent); Fla. Stat. Ann. § 393.13 (West 1993) (guardian of persons with developmental disabilities may provide informed consent to "experimental medical treatment" or "necessary surgical procedure," but treatment programs involving the use of noxious or painful stimuli prohibited); 405 I.L.C.S. 5/2-110 (Smith-Hurd 1996) (guardian may only consent to experimental treatment in the best interest of the ward); Mass. Regs. Code tit. 104 § 13.01-.05 (1995) (research on patients in mental facilities that will not provide direct, therapeutic

benefit not permitted; research on patients with mental disabilities where risk is more than minimal and exceeds the benefit to the subject is prohibited); Mo. Ann. Stat. § 630.115, § 630.192 (Vernon 1996) (involuntarily committed patients with mental disabilities may not be subjected to experimental research; biomedical or pharmacological research of no direct therapeutic benefit prohibited on patients with mental disabilities); N.J. Stat. Ann. § 30:4-24.2 (West 1981) ("Under no circumstances may a patient in treatment be subjected to experimental research which is not directly related to the specific goals of his treatment program") (provision governing the rights of patients generally); N.J. Stat. Ann. § 30:6D-5 (West 1981) ("Under no circumstances may a person in treatment be subjected to hazardous or intrusive experimental research which is not directly related to the specific goals of his treatment program") (provision governing the rights of persons with mental disabilities); 12 Va. Admin. Code 5-20-40 (Michie 1992) ("Nontherapeutic research using patients or residents within an institution as defined herein is forbidden unless it is determined by the research review committee that such nontherapeutic research will not present greater than minimal risk."). See also Section B, infra.

B. Many States, Like New York, Require Court Approval Before Administering Psychotropic Medications To Patients Incapable of Consent Or Approving Therapeutic Research

Many states require court approval even in cases of therapeutic treatment or research that carries a greater than

minimal risk. These states recognize, as does New York in N.Y. Mental Hygiene Law § 81.21 and Rivers, supra, that court approval is necessary to protect the interests of the research subject even when the project has the potential to directly benefit the patient. See also Alaska Stat. § 47.30.836 (1995) (court approval required prior to administration of psychotropic medication not in an emergency to a patient incapable of providing informed consent); Idaho Code § 66-405 (1995) (court approval required before guardian may consent to "experimental surgery, procedures or medications"); 405 I.L.C.S. 5/2-110 (Smith-Hurd 1996) (court approval required before guardian may consent to "unusual, hazardous or experimental services or psychosurgery" in the best interest of the ward); Minn. Stat. § 525.56 (1992) (court approval required for guardian consent to "experimental treatment of any kind"; court must find by clear and convincing evidence that treatment is in best interest of the ward, evaluating the risks of the procedure, whether less restrictive treatment is available, and the recommendation of the commissioner of human services); Nev. Rev. Stat. Ann. § 159.0805 (Michie 1993) (guardian must have court approval to consent to "experimental medical treatment" of the ward); N.H. Rev. Stat. Ann. § 463.12, 464-A:25 (1995) (guardian must have court approval to consent to "experimental treatment of any kind" for minor or incapacitated person); N.D. Cent. Code § 30.1-28-12 (1995) (no guardian consent to "experimental treatment of any kind" without court approval); 20 Pa. Cons. Stat. Ann. §§ 5100.54(VI)(2)(b),

5521 (1995) (no guardian consent to participation in any biomedical or behavioral experiment or "experimental treatments involving any risk to the patient" without court approval); N.H. Rev. Stat. 464-A:25(I)(c)-(e) (1995) (no guardian may consent, without court approval, to "experimental treatment of any kind," which may be approved only if in the best interest of the ward); S.D. Codified Laws Ann. § 27A-12-3.20 (Supp. 1996) (no experimental research on persons incapable of consenting without court order).

The remedy sought by plaintiffs here is no more restrictive than that endorsed by numerous other states, and provides an appropriate check on the potential conflict of interest and abuse that can otherwise occur, without any apparent detrimental impact on the progress of science.

IV. Conclusion

New York has long recognized the abuses that result from improperly regulated research, particularly on institutionalized persons with mental illness, who are disproportionately used in experimental research. The decision to participate in risky research that could potentially benefit society, but that is of no benefit to the individual, is a decision so critical and so personal that no surrogate should be permitted to make that choice without express guidance from the subject. In the absence of clear and convincing evidence of the wishes of an institutionalized patient who is now incapable of consent, researchers should not be permitted to perform non-therapeutic

research of greater than minimal risk. To do otherwise violates basic constitutional and common law rights, as well as fundamental principles of individual autonomy. The unacceptability of this sacrifice of individual rights is underscored by its lack of necessity, for no evidence exists that any essential scientific research will be lost as a consequence of the procedural protections that the individuals with mental disabilities in this case seek to ensure. A civilized society simply cannot allow persons with mental illness to be used as guinea pigs in risky experiments that carry only the possibility of benefiting someone else, without regard for the wishes of the individual subject.

Respectfully submitted,

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Of Counsel

APPENDIX

SUPREME COURT OF THE STATE OF NEW YORK
APPELLATE DIVISION: FIRST DEPARTMENT

T.D., et al.,	)	
	)	
Plaintiffs-Respondents-Appellants,	)	
	)	
v.	)	AFFIRMATION
	)	
THE NEW YORK STATE OFFICE OF MENTAL HEALTH, et al.,	)	
	)	
Defendants-Appellants-Respondents.	)	
	)	

ROBIN E. JACOBSOHN, an attorney duly admitted to the Bars of Pennsylvania and the District of Columbia, affirms under penalty of perjury as follows:

1. I am a partner in the law firm of WILLIAMS & CONNOLLY, counsel to The Bazelon Center for Mental Health Law ("the Bazelon Center") in this matter. I am familiar with the facts and circumstances herein set forth.

2. I submit this affirmation in support of the instant application by the Bazelon Center and others for leave to appear as amici curiae in the above-captioned matter, and to file the proposed brief attached as Exhibit A, in support of the position of the plaintiffs-respondents-appellants in their cross-appeal from a judgment of the Supreme Court, New York County (Greenfield, J.) invalidating regulations issued by defendant New York State Office of Mental Health ("OMH") that govern conduct of research on patients in facilities operated or licensed by OMH. The notice of appeal is attached as Exhibit B and the judgment appealed from is attached as Exhibit C.

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3. The brief of the proposed amici would be the only amicus brief submitted on behalf of plaintiffs. Two amicus briefs have been filed on behalf of defendants.

4. The proposed amici are rights and advocacy groups with particular expertise in the needs, interests and rights of individuals with mental disabilities, as described below.

5. The Bazelon Center (formerly the Mental Health Law Project), represented by undersigned counsel, is a national nonprofit public interest organization founded in 1972 to protect and advocate the rights of children and adults with mental disabilities. The Bazelon Center has been a leader in the field of mental disability law since its inception.

a. The work of the Bazelon Center has contributed to some of the leading Supreme Court decisions in the field of mental disability law, including Donaldson v. O'Connor, Addington v. Texas, and Bowen v. City of New York. The Center has also been of counsel in other major disability law cases in the Supreme Court, including City of Cleburne v. Cleburne Living Center and State of Washington v. Harper, and has participated as amicus curiae in at least a dozen others, including City of Edmonds v. Washington State Building Code Council, Zinermon v. Burch, and Jaffe v. Redmond.

b. The Bazelon Center has also played a major role in cases throughout the United States seeking to protect the rights of adults and children with mental illness or retardation, including New York Association for Retarded

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Children v. Carey, (deinstitutionalization of Willowbrook State School), Miles v. Board of Education (right of handicapped children to education), Dixon v. Weinberger (right to community services), Ihler v. South (freedom from abuse and undue restraint), Hunt v. Meszaros (rights to adequate habilitation and community services), U.S. v. Oregon (same), Wuori v. Zitnay (same), R.C. v. Hornsby (rights of abused and neglected children), K.L. v. Valdez (rights of children in custody to adequate treatment and community services), and M.E. v. Chiles (same).

6. The Bazelon Center's mission is the protection of the civil and human rights of adults and children who have mental disabilities. Those rights are directly threatened by provisions of the OMH regulations that permit biomedical research of substantial risk to be performed on institutionalized OMH patients without their informed consent. Because of its expertise in the issues raised by the OMH regulations, and its concern for the welfare of those subjected to them, the Bazelon Center joins plaintiffs in seeking invalidation of the challenged provisions.

7. Other proposed amici have requested that we submit information to the Court on their behalf so that they may be granted permission to join the brief.

a. Disabled in Action of Metropolitan New York ("DIA") is a civil rights organization dedicated to improving the legal, social, and economic condition of people with

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disabilities so that they may achieve complete integration into society. A number of DIA members, as children, were diagnosed with mental disabilities, and were subjected to sometimes risky medical procedures without their consent. DIA endorses medical research, but only where informed consent is provided by the research subjects.

b. The New York Association of Psychiatric Rehabilitation Services ("NYAPRS") is a statewide coalition of New Yorkers who are in recovery from a mental illness, and the professionals who work with them. Originally founded in 1981, NYAPRS also acts as the New York State chapter of the International Association of Psychosocial Rehabilitation Services. Through its member organizations, NYAPRS serves over 15,000 individuals who currently receive rehabilitation services. A priority of the organization is strengthening the rights of individuals recovering from mental illness -- in both in-patient and community settings. NYAPRS thus strongly opposes the current OMH policy and regulations pertaining to human experimentation, which threaten the rights, health and safety of individuals -- like many of its members -- diagnosed with mental illness.

c. The objective of the Mental Health Empowerment Project, Inc., a non-profit organization, is to maximize the freedom, independence and recovery of clients in the mental health system. It has helped start and works closely with over 500 self-help and advocacy groups and approximately 30 non-

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profit corporations run solely by mental health consumers. The clients served by the Mental Health Empowerment Project are subject to the OMH regulations at issue in this case, and thus have a strong and personal interest in ensuring adequate protection for proposed research subjects.

d. The National Association for Rights Protection and Advocacy ("NARPA") is the only national organization which addresses both mental health and retardation issues and which includes in its membership a broad spectrum of state departmental administrators, specialists in treatment and habilitation, professional advocates, and former and present recipients of mental health and retardation services. NARPA was formed in 1979 as a result of coordinating efforts of the National Institute of Mental Health. Among NARPA's hundreds of members are people who design, live, and work in community and institutional settings for people with mental retardation.

e. The Disability Rights Education and Defense Fund, Inc. ("DREDF") is a national organization dedicated to securing equal citizenship for Americans with disabilities. Since it was founded in 1979, DREDF has pursued its mission through education, advocacy and law reform efforts. Nationally recognized for its expertise in the interpretation of federal disability and civil rights laws, DREDF has consistently worked to promote the full integration of citizens with disabilities into the American mainstream, and to ensure that the civil rights of persons with disabilities are protected and advanced.

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f. Citizens for Responsible Care in Psychiatry & Research ("CRCP&R") is an advocacy and information network of concerned citizens -- including families, attorneys, physicians and patients -- for the purpose of advancing responsible and ethical care in the treatment of persons with neuropsychiatric brain disorders. CRCP&R was formed to ensure that the human rights of persons with severe mental impairments are respected, that they are not exploited in high-risk medical research which is not in their best interest, and that ethical standards -- including informed, comprehending consent -- are enforced. CRCP&R is fully supportive of ethical research to improve current treatment, find cures and/or preventive interventions of neuropsychiatric illnesses, and is committed to improving the quality of life for individuals with mental disabilities. CPCP&R does not, however, support the overreaching OMH regulations, and therefore joins plaintiffs in seeking invalidation of the challenged provisions.

g. The Consumer Information Network is wholly directed and operated by consumers of mental health services. The group's activities include the facilitation of communication among consumers and recipient-run organizations, and the provision of information and referral on a broad range of non-treatment services, such as self-help, advocacy, and entitlements. The Network opposes regulations such as the OMH regulations at issue in this case that place incapable patients in OMH facilities at risk of abuse.

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h. United Cerebral Palsy Associations of New York State, Inc. ("UCPA of NYS") is one of the largest providers of services to individuals with developmental disabilities and their families in New York State, and is the largest United Cerebral Palsy affiliate in the nation. Together with its 24 affiliates and divisions serving every county in the State, the UCPA of NYS network provides residential, health, clinical and advocacy services to over 30,000 individuals with disabilities and their families. Virtually all of UCPA of NYS members who reside in metropolitan New York are members of the plaintiff class in the Willowbrook case seeking improvements in the conditions at that state institution, and some of these residents were subjects of Willowbrook's experiments. UCPA of NYS is also a member of the national United Cerebral Palsy Associations, Inc., which coordinates services and advocacy for individuals with disabilities throughout the nation and funds significant research into the causes, prevention and treatment of developmental disabilities.

i. Lambda Legal Defense and Education Fund, Inc. ("Lambda") is a national, non-profit, public interest legal organization working for the civil rights of lesbians, gay men and people with HIV/AIDS through litigation, education and public policy work. Founded in 1973, Lambda is the oldest and largest legal organization addressing these concerns; in 1983, Lambda filed the nation's first AIDS discrimination case. Lambda has appeared as counsel or amicus curiae in scores of

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cases in state and federal courts on behalf of people living with HIV or other disabilities, including School Bd. for Nassau County v. Arline, 107 S. Ct. 1123 (1987), Chalk v. U.S. District Court, 814 F.2d 701 (9th Cir. 1988), Ratheon v. Fair Employment & Housing Comm'n, 212 Cal.App. 3d 1242 (1989), New York State Society of Surgeons v. Axelrod, 157 A.D.2d 54 (1990), Kerins v. Hartley, 27 Cal. App. 4th 1062 (1994), Owens v. Storehouse, 984 F.2d 394 (11th Cir. 1993), Bernstein v. Capitalcare, 70 F.3d 783 (4th Cir. 1995), and Mason Tenders Dist. Council Welfare Fund v. Donaghey, Civ. Action No. 93-1154, 1993 WL 596313, 2 A.D. Cases 1745 (S.D.N.Y. Nov. 19, 1993). Lambda is particularly familiar with the role that clinical trial research plays in the treatment of persons with HIV, and the issues of treatment access and autonomy in medical decision-making that are raised in the case before this Court.

j. The New York City Recipients' Coalition ("NYCRC") is an organization of consumers, survivors and ex-patients in the greater New York area. The NYCRC advocates on behalf of their members and provides them with a network of communication and information. NYCRC is strongly opposed to non-therapeutic experimentation on institutionalized OMH patients who have been deemed incapable of consenting to such experimentation.

k. The New York City Environmental Justice Alliance ("NYCEJA") strives for an end to racism and seeks environmental justice, including ensuring the rights of communities of color and low-income communities to equal protection and participation

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in environmental policy. The members of NYCEJA are in full support of a prohibition on research on individuals without their knowledge and informed consent. Principle No. 13 of the Principles of Environmental Justice, adopted October 7, 1991, reads: "Environmental justice calls for the strict enforcement of principles of informed consent, and a halt to the testing of experimental reproductive and medical procedures and vaccinations on people of color."

8. The proposed amici support the cross-appeal of plaintiffs because the relief sought is necessary to protect the civil and constitutional rights of all adults and children who have been diagnosed with mental illness and who are, or may in the future be, institutionalized in an OMH facility. Amici join plaintiffs in seeking to enjoin certain research permitted by the regulations, specifically (1) non-therapeutic research of greater than minimal risk on (a) adults who are incapable of giving consent and who have not previously executed an advance directive, or (b) children; and (2) therapeutic research of greater than minimal risk on incapable adults without prior court determination that (a) the patient is incapable of consenting, (b) the experiment directly benefits the patient, and (c) the experiment is in accordance with the patient's wishes and in the best interest of the patient.

9. The attached brief of the proposed amici will be of special assistance to the Court in several respects. It provides the collective expertise of numerous organizations

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dedicated to the rights and interests of individuals with mental disabilities, including those mental disabilities resulting from AIDS and Alzheimer's disease. The brief recounts the all-too-recent history of abuse of research subjects, and the ever-present need to ensure that such history is not repeated. It recounts how inherent conflicts of interest faced by physicians who act as scientific investigators inevitably lead to abuses of the civil and human rights of their subjects if proper controls over the process of obtaining informed consent are not in place -- controls that are conspicuously absent from the OMH regulations at issue here. The brief also refutes the unsupported assertion of defendants and their amici that research into the causes of mental disabilities, including those brought on by AIDS and Alzheimer's disease, cannot take place under the injunction sought, and demonstrates how the use of advance directives enables such research to continue while simultaneously protecting the rights of the subjects. The brief also demonstrates that many other states, in which research on patients in mental institutions is ongoing, employ much stricter regulatory regimes than under the invalidated OMH regulations. Because the brief will be of special assistance to the Court in these and other respects, an order permitting submission of the brief is appropriate under 22 N.Y.C.R.R. § 500.11(e)(3).

WHEREFORE, it is respectfully requested that this Court grant petitioners amici curiae status and permit them to submit the attached brief.

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STATE OF NEW YORK
COURT OF APPEALS

T.D., et al.

Plaintiffs-Appellants

v.

THE NEW YORK STATE OFFICE OF MENTAL HEALTH, et al.

Defendants-Respondents.

BRIEF OF THE BAZELON CENTER FOR MENTAL HEALTH LAW, GLOBAL LAWYERS AND PHYSICIANS, THE NATIONAL MENTAL HEALTH ASSOCIATION, THE NATIONAL ASSOCIATION FOR RIGHTS PROTECTION AND ADVOCACY, THE DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, CITIZENS FOR RESPONSIBLE CARE IN PSYCHIATRY AND RESEARCH, THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, UNITED CEREBRAL PALSY ASSOCIATIONS OF NEW YORK STATE, INC., NEW YORK CIVIL LIBERTIES UNION, THE MENTAL HEALTH ASSOCIATION IN NEW YORK STATE, INC., DISABLED IN ACTION OF METROPOLITAN NEW YORK, THE NEW YORK CITY RECIPIENTS' COALITION, THE NEW YORK CITY ENVIRONMENTAL JUSTICE ALLIANCE, THE NEW YORK ASSOCIATION OF PSYCHIATRIC REHABILITATION SERVICES, AND THE MENTAL HEALTH EMPOWERMENT PROJECT, INC.

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BRIEF FOR PROPOSED AMICI[1/]

Introduction

The post-World War II revelations of Nazi atrocities committed in the name of medical research prompted efforts to develop appropriate safeguards for the conduct of human experimentation. Yet the past 50 years have seen continued abuses, including the intentional exposure of unsuspecting subjects to live cancer cells, hepatitis, radiation and chemical warfare agents. While we cling to the illusion that such incidents are aberrations from the distant past, the reality is otherwise.

The experimentation at issue in this case, involving individuals with mental disabilities, presents unique ethical and legal issues because of the special challenge of obtaining meaningful informed consent. The Nuremberg Code, adopted in 1947 by the United States military tribunal overseeing the trials of Nazi war criminals, prohibits all research on persons incapable of providing informed consent. The regulations promulgated by the New York State Office of Mental Health ("OMH"), and invalidated by the Appellate Division in the opinion here on appeal, T.D. v. New York State Office of Mental Health, No. 58554, 1996 WL 695417 (N.Y. App. Div. 1 Dep't Dec. 5, 1996) ("Op."), took a step backward by permitting experimentation on

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[1/] See Affirmation in Support of Motion for Leave to Appear as Amici Curiae for a list of the Amici and a detailed description of their interest in this case and their work on behalf of individuals with disabilities.

incapable subjects -- with virtually no safeguards on the determination of incapacity or the use of surrogates to consent on behalf of "incapable" subjects -- even when the experiments offered no potential benefit for those subjects. While the opinion below addressed most of the flaws in the OMH regulations, it failed to complete that task by apparently and inexplicably excluding from the scope of the opinion (1) therapeutic research and (2) federally funded research. This appeal was filed to correct those omissions.

Institutionalized patients with mental disabilities, including the plaintiffs in this action, are uniquely vulnerable individuals who, in this country, are disproportionately used as subjects in experimental research. 45 C.F.R. § 46.111; American College of Physicians, Code of Medical Ethics, in Codes of Professional Responsibility 237, 276 (Rena A. Gorlin ed. 3d ed. 1994). See also infra note 25. This Court has the opportunity and, we submit, the obligation to ensure that researchers in New York are not permitted unilaterally to convert its most vulnerable citizens into "martyrs for science." Hans Jonas, Philosophical Reflections on Experimenting with Human Subjects, 98 Daedalus 219, 222, 245 (1969).

I. Procedural History

Plaintiffs are six individuals involuntarily committed to New York State psychiatric facilities who have at some point during their confinement been adjudicated incapable of providing informed consent and subjected to medical treatment (electroshock

therapy or psychotropic medications) over their objections. Their suit challenged research programs conducted at OMH facilities, both federally funded and non-federally funded, which permit experiments of greater than minimal risk on children and adults deemed incapable of providing informed consent. Included in the challenge were therapeutic research programs, which held out some possibility of direct benefit to the subject, and non-therapeutic research, which offered no possible benefit to the subject. Of the 400 ongoing research projects at OMH facilities, only 10 fell within the challenged categories. (Record on Appeal--"R."--25). Six of those projects were federally funded. Op. at *3. All 10 were categorized as experiments posing greater than minimal risk to their subjects.[2/] In the experiments challenged by plaintiffs, researchers have reported subject deaths, suicides, stroke, heart attacks, convulsions, hallucinations, Neuroleptic Malignant Syndrome and seizures. Op. at *1 n.1.

Plaintiffs' challenge focused on the OMH regulations on informed consent. These regulations allowed researchers, with an obvious interest in enlisting study participants, to pervade every aspect of the process for obtaining consent, and then

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[2/] "Minimal risk means that the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests." N.Y. Comp. Codes R. & Regs. tit. 14, § 527.10(c)(6).

perform experiments of substantial risk without the subjects' knowledge.

The Supreme Court granted summary judgment for plaintiffs, declaring that: 1) the challenged regulations promulgated by the OMH Commissioner are invalid and unenforceable because they exceeded his authority and lacked the consent of the Commissioner of Health -- in violation of Public Health Law ("PHL") Article 24-A; and 2) federally funded research carried out at OMH facilities in compliance with federal regulations is exempt from PHL Article 24-A. Order and Judgment (June 26, 1995), R. 38, 40-41.

The parties cross-appealed to the Appellate Division, First Department. The Appellate Division affirmed the Supreme Court's holding that the OMH regulations had been wrongly promulgated and were invalid. Op. at *17. The court further held that the regulations violated the Due Process Clauses of the United States and New York Constitutions and violated New York's common law right to privacy. Id.

The Appellate Division found that the critical determination under the OMH regulations was that of an individual's capacity to consent; once an individual is deemed "incapable," the regulations readily allow surrogates to consent to research, even over the individual's objection. Op. at *14-16. The court held that the regulations governing determinations of a potential subject's capacity -- which did not even provide for notice or review of such determinations -- failed to protect the

individual's due process rights under the New York and United States Constitutions. Id. The court declared that all subjects must be informed that their capacity is being evaluated in order to determine whether they can provide informed consent to proposed research. Op. at *14. In addition, the court construed both New York and federal constitutional law to require a judicial determination of capacity and an assessment of the risks and intrusiveness of the proposed research. Op. at *12-14 (citing Rivers v. Katz, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986); Washington v. Harper, 494 U.S. 210 (1990)).

The Appellate Division prohibited altogether the enlistment of children for non-therapeutic research of greater than minimal risk. Op. at *14. The Court further held that such research could only be performed on adults if the subjects had, when competent, given specific consent or designated a suitable surrogate from whom such consent could be obtained. Op. at *2.

The Appellate Division affirmed, without explanation, the Supreme Court's holding that its decision did not apply to federally funded research conducted at OMH facilities in compliance with federal regulations. Op. at *7.

With respect to the therapeutic research, the Appellate Division provided conflicting statements as to whether it was covered by the decision. Plaintiffs sought leave to appeal that portion of the Appellate Division's conclusion that its opinion does not apply to federally funded research, and to clarify the

court's ruling regarding therapeutic research. Plaintiffs' motion was granted by this Court on July 1, 1997.

II. Argument

A. The Procedural Protections Set Forth In The Appellate Division Opinion Should Be Construed To Apply To Therapeutic, As Well As Non-Therapeutic, Research Of Greater Than Minimal Risk

Although the Appellate Division's decision at one point suggests, in passing, that it does not affect "therapeutic" research on unconsenting subjects, Op. at *2, elsewhere the court makes clear that its holding applies to all greater-than-minimal risk experiments, whether therapeutic or not. For example, the opinion states that it addresses "research that offers no benefit or only minimal benefit to the subject." Op. at *11 (emphasis added). Therapeutic research, as defined under the OMH regulations, includes research that offers any prospect of benefit to the subject's health or well-being, however slim the prospect or marginal the benefit.[3/] Op. at *4 n.3. The court's statement that its reasoning applies to research which offers "only minimal benefit to the subject" thus necessarily means that its holding applies to therapeutic, as well as non-therapeutic,

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[3/] Moreover, because the regulations do not define the term "benefit," the researcher/IRB's determination that research is therapeutic rather than non-therapeutic is essentially unchecked. This highly subjective and unreviewable determination, if the court's opinion applied only to non-therapeutic research, could be used to circumvent the court's holding entirely; defendants could simply reclassify research as "therapeutic" and thereby avoid the protections the court found were necessary under the common law and the New York and Federal constitutions for non-therapeutic research.

research. Indeed, the court offered no explanation or justification for excluding therapeutic research.

Even if the Appellate Division intended to leave in place the OMH regulations as they pertain to therapeutic research, such a result would be contrary to both the court's own analysis and the binding precedent on which it purported to rely.

In holding that a judicial determination of capacity is required, the Appellate Division opinion relies heavily on Rivers v. Katz, in which this Court upheld the rights of involuntarily committed persons with mental disabilities to refuse antipsychotic medication. The holding in Rivers derives from the individual's rights to privacy and bodily integrity, rights with well-established common law and constitutional underpinnings. The Rivers court found that to protect these interests, a judicial determination of incapacity is necessary before antipsychotic medication may be administered to an unconsenting patient. If a court determines that the patient lacks the requisite capacity for consent, a second determination would then be necessary to ensure that the proposed medication is "narrowly tailored to give substantive effect to the patient's liberty interest." 67 N.Y.S.2d at 497, 504 N.Y.S.2d at 81. Such a determination would take into account "the patient's best interests, the benefits to be gained from the treatment, the adverse side effects associated with the treatment and any less intrusive alternative treatments." Id. at 497-98, 504 N.Y.S.2d at 81. Moreover, "[t]he State would bear the burden to establish

by clear and convincing evidence that the proposed treatment meets these criteria." Id.

As the Appellate Division recognized, the rights to privacy and bodily integrity held fundamental in Rivers are no less fundamental in the research context. Only two factors distinguish "therapeutic" research, as defined under the OMH regulations, from the medical treatment discussed in Rivers. Both of those factors argue for greater -- not lesser -- protection in the research context.

First, the "benefit" which distinguishes therapeutic from non-therapeutic research may be far more remote and speculative than the undisputed immediate benefit considered in Rivers. The Rivers court found that the medication at issue there "may be beneficial or even necessary to preserve the patient's life." Id. at 493, 504 N.Y.S.2d at 78; see also id. at 490 n.1, 504 N.Y.S.2d at 76 n.1 (finding that antipsychotic drugs are "widely used in the treatment of mental illness"). By contrast, under the OMH regulations the "prospect of benefit" offered by therapeutic research may be no more than "minimal." Op. at *11. As the court below properly found, "it is apparent that 'a prospect of direct benefit' important to the general health or well being of the subjects is something significantly less than what is expected or intended in a treatment context." Id. at *14 (emphasis added). Given the more speculative nature of the benefit involved in human experimentation, research subjects are entitled, at a minimum, to the same procedural safeguards

available to patients identified as candidates for medical treatment.

The second difference between medical treatment and therapeutic research is the greater likelihood, in the research context, that the researcher's interests may diverge from, or be adverse to, those of the subject. As the Appellate Division recognized, in the treatment context the "sole motivation is a beneficial therapeutic effect on the patient." Id. at *11. By contrast, the researcher's agenda often fails to serve, or even conflicts with, the needs of the subject. See discussion infra, Section II.C.2.b. If anything, this potential for conflict should trigger greater judicial skepticism of the researcher's unilateral assessment of what constitutes a "prospect of benefit" sufficient to qualify as "therapeutic" research. As a result, this factor also weighs in favor of equal, if not more rigorous, procedural protections than those required under Rivers for the administration of medical treatment.

Thus, to the extent that Rivers can be distinguished from this case, the result would accord greater -- not lesser -- procedural protection to subjects of therapeutic research than to patients receiving medical treatment. The logic of the Appellate Division's opinion and the precedent established in Rivers can lead to only one conclusion: the court's holding must apply to all greater-than-minimal risk research -- both "therapeutic" and "non-therapeutic."

B. The Appellate Division Erroneously Concluded That Its Holding Did Not Apply To Federally Funded Research

1. The Appellate Division Decision Provides No Justification For Excluding Federally Funded Research From The Scope Of Its Opinion

Without explanation or elaboration, the Appellate Division concluded, in a single sentence, that its holding did not apply to federally funded research: "Moreover, the fact remains that the large majority of studies, which are therapeutic and/or proceed upon the informed consent of subjects or are federally funded, will remain unaffected." Op. at *2 (emphasis added). The only possible rationale found anywhere in the opinion is the observation that "research subject to and conducted in compliance with the Federal regulations governing the protection of human subjects is not subject to [New York] Public Health Law Article 24-A, [§ 2445 of which] expressly provides that the provisions of Article 24-A shall not apply to such research." Op. at *9. However, that observation, even if true, has no bearing on the substantive (constitutional and common law) holdings in the Appellate Division opinion.

The relevance of Article 24-A in both the trial and appellate court decisions was limited to the analysis of whether the OMH regulations were promulgated in compliance with the statutory authorization contained in Article 24-A, and in compliance with Article 24-A's requirement that the Commissioner of Health consent to the conduct of research on those with mental disabilities. See Op. at *5-10. Once the Appellate Division determined that the regulations were not properly promulgated

pursuant to Article 24-A, it then found that defendants would continue to carry out the challenged experimentation, and the Court turned its attention to the need for setting out guidelines for the conduct of future research: "Therefore, analysis of the plaintiffs' constitutional and common law claims is appropriate." Op. at *11. See also Op. at *11-19 (analyzing the challenged portions of the OMH regulations and concluding that they violate various provisions of New York common and constitutional law, as well as the United States Constitution). Thus, the determination of the appropriate guidelines for the conduct of experimental research was based expressly on an analysis of constitutional and common law requirements -- without reference to or reliance upon Article 24-A or any other aspect of New York statutory law.[4/] As a result, the language of § 2445 of Article 24-A -- which excludes from that statute's coverage any research conducted subject to, and in compliance with, federal regulations -- has no relevance to the common law and constitutional analysis, or the applicability of that analysis to all research, regardless of the source of funding.

In other words, § 2445 merely limits the scope of a particular state statute (Article 24-A); it does not attempt to exempt federal research from the applicability of state common law privacy protections, or from state or federal constitutional

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[4/] The only exception is the portion of the OMH regulations allowing for interference with the parent-child relationship, which was held to violate Article 6, Title I of the New York Social Services Law. Op. at *20.

law. Nor could it. As set forth in Section II.B.2 below, no state statute could exempt federally funded research from the requirements of state or federal constitutional law. Moreover, New York state statutes are only construed to abrogate the common law when "the clear import of the language used in a statute absolutely requires." N.Y. Statutes Law § 301(b) (McKinney 1971). In this case, nothing in the language or Article 24-A even suggests an intent to supersede New York common law privacy protections -- let alone requires such an interpretation. Accordingly, the Appellate Division erred in stating that federally funded research would not be affected by its substantive analysis of the common law and constitutionally mandated protections governing human experimentation.

Moreover, as explained in Section II.B.3 below, the federal regulations themselves incorporate more protective state law. As a result, all experimental safeguards mandated by the Appellate Division decision are necessarily and automatically incorporated into the federal regulations, and are thereby applicable to federally funded research, whether or not the Appellate Division so recognized.

2. The Constitutional Holdings Of The Appellate Division Decision Necessarily Apply To Federally Funded Research

The Appellate Division properly held that the research practices at issue here violate the subjects' rights to procedural due process under the New York and United States Constitutions. Each individual enjoys a fundamental liberty

interest in his or her bodily autonomy and freedom from non-consensual invasive procedures. Rivers v. Katz, 67 N.Y.2d 485, 504 N.Y.S.2d 74 (1986); Washington v. Harper, 494 U.S. 210 (1990). To protect the individual's right to determine what shall be done with his or her body, any practices which intrude upon this interest must be accompanied by procedural safeguards to protect against an erroneous deprivation. Rivers, 67 N.Y.2d 485, 504 N.Y.S.2d 74; Washington, 494 U.S. 210. Whether the funding source of the research is state, federal or private dollars makes no difference to this constitutional analysis. Thus, although the Appellate Division found that Article 24-A was inapplicable to federally funded research, that interpretation would in no way undermine the applicability of the constitutional rulings to all of the research projects challenged here -- both state and federal. The New York legislature could no more exempt state or federal programs from constitutional requirements than could the United States Congress. E.g., Fullilove v. Klutznick, 448 U.S. 448, 526 (1980) ("[I]n the exercise of its powers, Congress must obey the Constitution just as the legislatures of all the States must obey the Constitution in the exercise of their powers. If a law is unconstitutional, it is no less unconstitutional just because it is a product of the Congress of the United States.").

The research practices held unconstitutional by the court below include surrogate consent to experimentation on human subjects without a judicial determination of the subjects'

capacity to consent or object to potentially harmful research; experimentation on those subjects without notice to them or an opportunity for review of the researcher's determination of the subject's incapacity; and potentially harmful research on minors and adults which offers no prospect of benefitting them. Notice and an opportunity for impartial review of adverse determinations are completely absent. These practices thus lack even the most basic procedural protections for the physical safety of their intended subjects, much less their liberty interest. Op. at *13-14 (citing Rivers, 67 N.Y.S.2d at 498, 504 N.Y.S.2d at 81; Washington, 494 U.S. 210; Riggins v. Nevada, 504 U.S. 127 (1992)).

Because the continued use of incapable subjects for scientific research, without their consent or even knowledge, intrudes upon fundamental rights, Defendants must articulate a compelling state interest, and the suspect practices must be narrowly tailored to serve that interest. E.g., Skinner v. Oklahoma, 316 U.S. 535 (1942). The only interest Defendants have articulated in their pleadings is the interest of the scientific community in medical advances. However, Defendants below offered no substantive proof that this interest was threatened by the procedural protections advocated by Plaintiffs. The absence of such proof is fatal to their argument. Under a strict scrutiny analysis, speculative harms may not rise to the level of a compelling state interest. E.g., Bernal v. Fainter, 467 U.S. 216, 227-228 (1984) (statute requiring notaries to be United

States citizens violates equal protection absent "a factual showing that [the asserted interest] presents a real, as opposed to a merely speculative, problem to the State"); Tinker v. Des Moines Independent Community Sch. Dist., 393 U.S. 503, 508, 514 (1969) (finding unsubstantiated fear of classroom disruption insufficient to overcome fundamental right to free expression).

Defendants have presented no record evidence to substantiate their claim that research will be stymied unless researchers are permitted to use as subjects individuals with mental disabilities and/or minors, without their knowledge or consent. To the contrary, the evidence demonstrates that protecting the civil rights of persons with mental disabilities is fully consistent with the continued accumulation of scientific knowledge. See infra, Section II.D.

Even if Defendants could substantiate some negative effect on research, they could not justify the underlying assumption that it is acceptable intentionally to sacrifice the physical safety and civil rights of our most vulnerable citizens in the hope that someday their research might benefit others. With regard to non-therapeutic research of more than minimal risk, it is fundamental that "[o]ne is not obliged to do a small good to society at the expense of great harm to oneself." David Hume, Essay on Suicide, in Moral Problems in Medicine (Samuel Gorvitz et al. eds., 1976). See also Rivers v. Katz, 67 N.Y.2d 485, 496 n.6, 504 N.Y.S.2d 74, 80 n.6 (1986) (rejecting "[a]ny implication that State interests unrelated to the patient's well-being or

those around him can outweigh his fundamental autonomy interest").[5/] Conversely, the Hippocratic maxim "do no harm," when applied to research, means that doctors should not knowingly injure some in order to attain hoped-for benefits for others. National Comm'n for Protection of Human Subjects of Biomedical & Behavioral Research, Belmont Report 4 (Apr. 18, 1979). Yet that is precisely what the invalidated OMH regulations permitted researchers to do to institutionalized research subjects.

Finally, even if Defendants could establish that their speculative fears about medical advances constituted a compelling interest, they could not demonstrate that the research practices at issue are narrowly tailored to serve that interest. There is no basis for believing that the use of advance directives will fail to yield ample subjects for necessary experiments. See Section II.D.1, infra. Nor is there any proof in the record that the same research goals could not be achieved with experiments limited to capable subjects.

3. Federally Funded Research, By Operation Of The Federal Regulations, Is Governed By More Protective State Law

As outlined below, the federal regulations which govern the conduct of federal research themselves incorporate more protective requirements of state law. As a result, all the procedural safeguards set forth in the Appellate Division opinion

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[5/] In cases of therapeutic research, the need for safeguards protecting a subject's health and liberty interests is also clear. See supra Section II.A.

are automatically and necessarily made applicable to federally funded research.

a. The Federal Regulations Are Designed To Allow More Protective State Law To Take Precedence

As their language and history demonstrate, the federal regulations at issue here, promulgated by the United States Department of Health and Human Services ("HHS"), clearly provide that state and local laws which accord greater protections to human subjects shall continue to govern federal research programs. Section 46.101(f) broadly states that "[t]his policy does not affect any state or local laws or regulations which may otherwise be applicable and which provide additional protections for human subjects." 45 C.F.R. § 46.101(f).[6/] Provisions specific to informed consent echo this basic principle. Thus, Section 46.116, which identifies certain information that must be provided to a subject in order to obtain consent in federally funded programs, similarly states that "[t]he informed consent requirements in this policy are not intended to preempt any applicable federal, state, or local laws which require additional information to be disclosed in order for informed consent to be legally effective." 45 C.F.R. § 46.116(e).[7/]

[6/] This language parallels the succeeding section, which provides that "[t]his policy does not affect any foreign laws or regulations which may otherwise be applicable and which provide additional protections to human subjects of research." 45 C.F.R. § 46.101(g).

[7/] See also § 46.201(b) (providing additional protections for pregnant women: "Nothing in this subpart shall be construed as indicating that compliance with the procedures set forth herein will in any way render inapplicable pertinent State

The FDA's interpretation of its research regulations, which it adopted from, and which are identical to, the HHS regulations,[8/] further underscores the continuing applicability of state law to federal research. This can be seen from FDA's commentary on its own subsequently promulgated rule governing emergency medical research: "[p]reemption of state law would prevent the application of State or local law that requires additional protections to research subjects and, as such, would be inconsistent with the existing Federal policy for the Protection of Human Subjects and the DHHS regulations (45 CFR 46)." 61 Fed. Reg. 51,498, 51,502 (1996). Because it recognized and endorsed the continued applicability of non-federal requirements, the agency advised institutions to work with counsel to ensure compliance with state and local law:

> FDA is not changing the existing Federal policy that recognizes the continuing validity of applicable State or local laws and regulations on human subject protections. . . . FDA notes that this rule does not override existing State and local laws and regulations

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or local laws bearing upon activities covered by this subpart."); § 46.301(b) (providing additional protections for prisoners: "Nothing in this subpart shall be construed as indicating that compliance with the procedures set forth herein will authorize research involving prisoners as subjects, to the extent such research is limited or barred by applicable State or local law."); § 46.408(c) (authorizing waiver of parental consent to treatment of children under limited circumstances: waiver must not be "inconsistent with Federal, state or local law").

8/ In 1991, 15 other federal agencies, including the FDA, adopted regulations identical to the HHS regulations (now known as the "Common Rule"). GAO, Scientific Research: Continued Vigilance Critical to Protecting Human Subjects (Mar. 1996) ("GAO Report") at 3; 58 Fed. Reg. 28,003, (1991).

> that may apply to such research. Institutions wishing to participate in such research may wish to consult their attorneys regarding any State and local restrictions that preclude such research. As with other research, physician liability for activities engaged in during emergency research will vary from State to State because of different laws on human subject protections.

61 Fed. Reg. at 51,504 (emphasis added).

b. The Federal Regulations Incorporate Relevant State Law

Beyond the guiding principle that more protective state law will govern federal research, certain key provisions in the HHS regulations -- without which the regulations would be incomplete and compliance could not be determined -- expressly incorporate the requirements of state and local law. They do so by repeatedly incorporating the definitions and requirements of applicable law in circumstances -- relating to informed consent and surrogate decision-making, and thus directly relevant here -- where the only applicable law is state law. For example, § 46.102(c) provides that "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." There is no applicable federal law which authorizes individuals or others to provide such consent; the only available source is state law. Indeed, the FDA's interpretation of the term "legally authorized representative" -- derived from, and identical to, the HHS regulation 46 Fed. Reg. 8942 (1981) -- makes clear that this term is specifically and commonly

understood to incorporate state law requirements. See, e.g., 61 Fed. Reg. 51,498, 51,502 (1996) (noting the complications resulting from state laws that differ in their definitions of who may serve as a legal representative); 61 Fed. Reg. at 51,506 (explaining that consent of family member "may not constitute legally effective informed consent if the family member is not a legally authorized representative under State law").

Other critical provisions of the HHS regulations similarly incorporate state law requirements. See, e.g., § 46.402(a) ("Children are persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted."); § 46.402(e) ("Guardian means an individual who is authorized under applicable State or local law to consent on behalf of a child to general medical care."); § 46.116 ("[N]o investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative." (emphasis added)). These sections all require reference to state and local laws to determine the criteria for informed consent and surrogate decision-making, and reflect federal solicitude for state and local laws which are more protective of the rights of human subjects.

Of particular significance is the requirement in the HHS regulations that an investigator obtain the "legally effective

informed consent of the subject or the subject's legally authorized representative." § 46.116 (emphasis added). Because the HHS regulations are silent as to what constitutes "legally effective" informed consent, that determination necessarily depends on state law, which is thereby effectively incorporated into the Federal regulations. The state law determination of "legally effective" consent, in turn, depends on state law standards for assessing a subject's capacity for informed consent. The "consent" of an incapable person would not be "legally effective" under state law. Moreover, only after a prospective subject is deemed incapable of providing consent, under whatever procedures are mandated by the applicable state law, may the subject's "legally authorized representative" provide the required consent.[9/]

The federally funded studies at issue in this case are themselves evidence that even defendants recognize that the HHS regulations incorporate state law. As explained in Section

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9/ Indeed, the language of this provision makes sense only if it is read to incorporate state law governing capacity to consent. The phrase "legally effective" modifies and applies to the informed consent of both the subject and the legally authorized representative. If the consent obtained from an incapable subject were deemed "legally effective," despite the subject's lack of capacity, there would never be any need to solicit consent from the subject's "legally authorized representative." Conversely, "legally effective" consent from a "legally authorized representative" can only be obtained after a determination that the subject could not provide "legally effective" consent -- absent a judicial determination of incapacity, a surrogate is not a "legally authorized representative."

II.C.1. infra, most of those study protocols expressly incorporate the (now-invalidated) OMH regulations.

To construe the federal regulations as not incorporating state law, and therefore as immune from the requirements of the Appellate Division opinion, would run afoul of both the New York and United States Constitutions. See discussion, supra, Section II.B.2. Such a result contravenes the well-established principle that courts should construe legislation and regulations in a manner to avoid constitutional violations.[10/]

C. The Details Of The Federal Research Projects At Issue Here, And The History Of Research Abuse In This Country, Underscore The Necessity For Applying The Appellate Division Opinion To Federally Funded Research Programs

1. The Details Of The Federally Funded Research Projects Reflect A Failure To Ensure Truly Informed Consent By The Subjects

Plaintiffs challenge six federally funded experiments. R. 2562 (Delano Affidavit). As will be discussed in Section C.2, infra, these federally funded research projects do not -- absent application of state law, as set forth in the Appellate Division opinion -- sufficiently protect against researcher biases and surrogate conflicts, which significantly undermine the consent

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10/ SSC Corp. v. Town of Smithtown, 66 F.3d 502, 518 (2d Cir. 1995) ("It is axiomatic that we prefer constructions of ordinances and statutes that do not conflict with the Constitution." (citing Ashwander v. Tennessee Valley Auth., 297 U.S. 288, 346-48 (1936) (Brandeis, J., concurring) ("When the validity of an act of the Congress is drawn in question, and even if a serious doubt of constitutionality is raised, it is a cardinal principle that this Court will first ascertain whether a construction of the statute is fairly possible by which the question may be avoided" (quotation omitted)), cert. denied., 116 S. Ct. 911 (1996).

process. Five of the six studies are briefly described below.[11/]

a. Haloperidol Treatment In Alzheimer's Disease

This study analyzes the effect of haloperidol, a drug commonly used for treating schizophrenia, on patients with Alzheimer's disease, a large number of whom take this drug to control psychoses and other behavioral disturbances. R. 0831. Although federally funded, the researchers conducting this study adopted the OMH regulations governing evaluation of a subject's incapacity and means for obtaining surrogate consent. R. 0831.

The pilot study indicated that haloperidol in the high dosage (the most common dosage) produces significant side effects and may result in measurable cognitive deterioration within a few weeks. One subject in the study required emergency hospitalization for seizures. R. 0837. According to the research protocol, one hypothesis to be tested was that "[t]he placebo and low dose conditions result in minimal or no cognitive deterioration, while a substantial proportion of patients in the high dose condition develop cognitive impairment . . . ." R. 0831. The study was thus undertaken with the expectation that subjects to be given the high doses would suffer severe and rapid adverse effects. Regional cerebral blood flow ("rCBF") of

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11/ Defendants never produced any documents relating to the study titled Neuropathology of Dementia in Elderly Schizophrenic Patients; therefore, no description of it is available in the record.

subjects is measured through a procedure requiring the subject to breath ionizing radioactive gas. R. 2194.

Although the original research protocol called for a two-week "washout" period -- a complete withdrawal from all medications -- this requirement was eliminated in 1989 because it hampered efforts to recruit subjects. R. 0835, 0843. Instead, the researchers simply changed the study protocol to begin with a one-week, undisclosed placebo phase for all subjects. R. 0843. This was done despite the fact that experiments requiring withdrawal of antipsychotic medication are particularly high risk. See, e.g., Richard Jed Wyatt, Risks of Withdrawing Antipsychotic Medications, 52 Arch. Gen. Psychiatry 205 (1995).

The "patient" consent form does not advise potential subjects that they will be subjected to a complete withdrawal from all medications that treat psychosis or other behavioral disturbances, or that such withdrawal can result in recurrence of their original symptoms. R. 2194-95. Potential subjects are also not informed that a high dosage of haloperidol (the common dosage) can result in significant mental deterioration within a few weeks. Id. Subjects are told that one side effect of taking haloperidol is development of tardive dyskinesia (awkward involuntary movements) that some suffer for years after taking the medication. Id.

b. Serotonin In Treatment Of Refractory Schizophrenia

This study assesses the functioning of a brain chemical in mental illness through use of an experimental drug. R. 2344.

Subjects withdraw from all medication for four weeks prior to participation. After that period, subjects are treated with haloperidol. If haloperidol is not effective, subjects are then treated with clozapine, a drug with more dangerous side effects than haloperidol. R. 1664.

Clozapine can cause agranulocytosis, a severe drop in a subject's white blood cell count that can lead to serious infection and possibly death. R. 2392 (Physician's Desk Reference ("PDR") entry for clozaril/clozapine). One of 100 persons taking the drug may develop a low white blood cell count, and two in 1,000 may die from the condition. R. 1969 (consent form from a privately funded clozaril study). Another substantial risk of clozapine is seizures. R. 1970 (drug company consent form); R. 2392 (PDR entry).

The consent form for the study in this case advises potential subjects that the risk of side effects is unknown because the drug used to measure the brain chemical has not previously been used in schizophrenic patients. The form mentions the risks of tardive dyskinesia and "aggravation" of symptoms during the washout period. R. 1680. Subjects are not informed of the risk of seizures. R. 2344-45. Subjects are informed of the risk of agranulocytosis, but are not told that the condition is life-threatening, nor are they told of the likelihood of developing the condition or its early warning signs. Compare R. 2344-45 with R. 1970.

Surrogate consent for this study was obtained in accordance with the OMH regulations. R. 2349 (surrogate consent form provides that surrogate consent may be obtained, without any priority, from an individual designated by the patient, an individual with a power of attorney, spouse, parent, adult child, adult sibling, guardian, close friend,[12/] or court of competent jurisdiction).

c. Toward A Rational Use Of Plasma HVA In Mental Illness

The goal of this study is to determine which aspects of schizophrenic illness can be detected by variations in plasma homovanillic acid (pHVA) concentrations. R. 1762. Surrogate consent to research was obtained for this study pursuant to OMH regulations. R. 2364.

During four or more weeks of the study, the subjects are withdrawn from all medications. R. 2356. Subjects are informed that the risks of this phase are "very low," but that they may experience reemergence or intensification of their symptoms. Subjects receive clozapine during four weeks of the study. Although told of the risk of a low white blood cell count, subjects are not informed of the likelihood of the condition

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12/ "Close friend" is defined in the OMH regulations as "an adult who presents an affidavit to the director which states that he is a close friend of the patient and that he has maintained such regular contact with the patient to be familiar with the patient's activities, health, and religious or moral beliefs and stating the facts and circumstances that demonstrate such familiarity." N.Y. Comp. Codes R. & Regs. tit. 14, § 527.10(c)(3).

(beyond that it is "relatively infrequent"), or any risk of death or seizures. Compare R. 2356 with R. 1970.

d. RCBF In Alzheimer's Disease

This non-therapeutic study analyzes regional cerebral blood flow ("rCBF") in Alzheimer's patients as compared to individuals without Alzheimer's. R. 1527, 1533. Regional cerebral blood flow is measured by exposing subjects to ionizing radiation (133-Xenon) four times per year. Although the study is officially denoted as one of greater than minimal risk, the consent form describes the study as one of "minimal risk." R. 2308.

The study physician and a member of the treatment team determine whether a potential subject is capable of providing informed consent. R. 2308. Surrogate consent was provided pursuant to OMH regulations. R. 2309.

e. Prognostic Markers Of Very Poor Outcome Schizophrenia

The aim of this research project is to find biological or symptomatic features that predict very poor outcome schizophrenia by studying one group of subjects who have had the illness for less than five years, and another group who have had the illness for longer than five years. R. 1523. Ventricular asymmetry (differences in the ventricles in the brain) is analyzed, as is the subject's response to haloperidol and his or her family history. R. 1520.

Subjects are withdrawn from all medication for at least 14 days before entering the study. R. 1519. Researchers assessed

the capacity of subjects and obtained surrogate consent pursuant to the OMH regulations. IRB Manual, 1/25/94, at 44-51.

2. The History Of Research Abuses Highlights The Dangers Of Excluding Federally Funded Experiments From The Requirements Of The Appellate Division Decision

The long history of research abuse in this country makes clear that federally funded programs must not be insulated from the procedural protections imposed by the Appellate Division decision. Unfortunately, under the Appellate Division's incomplete holding, the very practices found to violate New York and Federal constitutional law continue to be employed when the funding source is federal dollars. Only by applying the Appellate Division's opinion to federally funded research can this Court protect subjects from (i) the inevitable conflicts of interest faced by researchers, and (ii) the problems inherent in permitting a broad range of surrogates unfettered discretion to consent to research without regard to the subject's wishes or best interest.

The OMH regulations allowed the researcher to pervade every aspect of the process for obtaining consent, and then perform experiments of substantial risk on subjects without their knowledge. The researcher, alone, could determine whether a potential subject was incapable of consenting. R. 2635. After deciding that a person was incapable, the researcher could choose not to inform the subject that he would be participating in non-therapeutic research of greater than minimal risk. The researcher could then "forum shop" amongst potential surrogates

In a study at the Neuropsychiatric Institute of the University of California, Los Angeles ("UCLA"), conducted between 1988 and 1994, schizophrenic patients whose psychoses had been controlled with medication were suddenly withdrawn from that medication in the expectation that a relapse (recurrence of symptomatology) in many patient-subjects would result. Jay Katz, Human Experimentation and Human Rights, 38 St. Louis U. L.J. 7, 41-51 (1993). The object of the study was to improve prediction of relapse, particularly of those who would exhibit "bizarre behavior, self-neglect, hostility, depressive mood and suicidability." Id. at 41-42 (quoting the research protocol). The consent form did not reveal, however, that those particular symptoms were almost 90 percent likely to recur upon sudden withdrawal of the medication. Id. at 46. To the contrary, the consent form promised that subjects would receive "regular care," without making clear that withdrawal of medication would probably undermine their care. Id. at 44-45. In 1994, NIH reprimanded the scientists in charge of the study for failing to obtain proper consent from patients before withdrawing the medication.[16/]

Subjects participating in the federally funded experiments at issue in this case are similarly not told of significant risks. One study categorized as greater than minimal risk is inaccurately described in the consent form as posing only

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16/ Philip J. Hilts, Agency Faults a UCLA Study for Suffering of Mental Patients, N.Y. Times, Mar. 10, 1994, at A1.

"minimal risk." R. 2308. Moreover, at least four of the six studies require subjects to withdraw completely from medication treating their schizophrenia or other psychoses. In the study of haloperidol use by subjects with Alzheimer's disease, researchers deliberately changed the protocol so that subjects would not be told that the study begins with a one-week placebo phase, because researchers found it difficult to recruit subjects after disclosing the required withdrawal from medication. R. 0835. In studies requiring much longer washout periods, potential subjects are not told the likelihood that complete withdrawal from schizophrenia medications will result in recurrence of severe symptoms, or that complete withdrawal can significantly undermine their care. See R. 1680 ("aggravation" of symptoms may occur during withdrawal phase); R. 2357 ("it is possible that you may experience a reemergence or intensification of some of the symptoms that necessitated medications in the first place" (emphasis added)).

In addition, potential subjects in the federally funded programs at issue are not fully informed of the side effects of the drugs they will receive. Subjects with Alzheimer's disease are not told of the significant cognitive deterioration they could suffer should they receive the high dosage of haloperidol rather than the placebo or low dosage. R. 2194-95. Nor are subjects told that clozapine has a life-threatening side effect, as well as the potential for causing seizures. R. 2344-45, 2194-95.

These studies are examples of how double-blind, controlled experiments, particularly ones requiring withdrawal of all medications from schizophrenic subjects, are inconsistent with appropriate medical treatment for those subjects. Research proceeds according to a detailed and largely inflexible protocol, whereas clinical practice, or therapy, depends on highly individualized and nuanced, even ad hoc, dosage adjustments and changes in therapeutic tools. Robert J. Levine, Informed Consent in Research and Practice, 143 Archives of Internal Med. 1229, 1231 (1982). Thus, the inflexibility required by scientific inquiry can be detrimental to the welfare of the patient requiring individualized care. In short, research deemed non-therapeutic can often be anti-therapeutic -- heightening the need for procedures that will ensure a truly informed decision to participate.

These recent examples are not rare aberrations, but rather are representative of a pervasive problem. The director of NIH's human subject protections program states that the problems in obtaining informed consent at VA hospitals appear to be "systemic." Sloat & Epstein, supra. Prominent researchers recently noted that "[t]he UCLA case reported in the lay press is not an isolated example, but an indication of possible serious and widespread lapses in the protection of vulnerable patients." Adil Shamoo & Timothy Keay, Ethical Concerns About Relapse Studies, 5 Cambridge Q. Healthcare Ethics 373, 383 (1996). See also Katz, supra, at 50-51.

Congressional hearings held in May of 1997 produced one estimate that 50 percent of all federally funded research inspected by the FDA between 1977 and 1995 was conducted without the fully informed consent of the participants. Statement of Representative Christopher Shays, Hearing on Biomedical Ethics, May 8, 1997, at 1. See also GAO Report at 14. In an analysis of drug research projects between 1980 and 1995, the General Accounting Office discovered 84 deficiency citations in the records of the FDA, including: citations for inadequate and forged informed consent forms; failure to inform subjects that drugs were experimental; failure to report adverse reactions to drugs under study, including a subject's death; and proceeding with a cancer study after it had been suspended by the FDA. See GAO Report at 13-14. In a separate analysis of persons disciplined for scientific misconduct, investigators reviewed FDA files of clinical trials between 1975 and 1983. The investigators discovered that 44 percent of those disciplined had failed to obtain informed consent; 59 percent falsified data and 37 percent failed to obtain IRB approval for the study. Martin F. Shapiro & Robert P. Charrow, Scientific Misconduct in Investigational Drug Trials, 312 New Eng. J. Med. 731, 734 (1985). Inadequate and incomplete consent documents constituted 37 percent of the deficiencies reported by FDA inspectors of VA hospitals between 1990 and 1995. Sloat & Epstein, supra. Recognizing past failures in obtaining informed consent in federally funded programs, the National Institute of Mental

Health ("NIMH") has begun a study of informed consent practices in mental health research. USA Politics: Apologizing for Tuskegee, Economist, May 19, 1997.

As these recent examples demonstrate, failure to obtain informed consent from subjects of biomedical research is a present and persistent problem, particularly in federally funded programs. The need for adequate regulation is great because the individuals affected by the challenged aspects of these federally funded programs are among the most vulnerable members of society -- adults and children with psychiatric or cognitive impairments, like Alzheimer's disease or schizophrenia, who are committed to mental hospitals and who have been (or will be) deemed incapable of providing informed consent.

b. Researchers Face Inherent Conflicts That Impair Their Ability To Ensure That Consent Is Informed And Meaningful

Researchers constantly face a conflict between obtaining fully informed consent from research subjects -- a difficult task under any circumstances -- and advancing their research projects by persuading potential subjects to participate. Researchers have a tendency to minimize the risks of their own projects, inadvertently downplaying the potential individual harm that can result when they perceive the long-term benefits to society as significant. See, e.g., David J. Rothman, Strangers at the Bedside 56-81 (1991). Indeed, the American Psychological Association has long recognized that personal involvement of the researcher in the consent process may lead to exaggeration of the

scientific merit of the proposed research and underestimation of the costs to the research participant. APA, Ethical Principles in the Conduct of Research with Human Participants 20 (1982). Although a researcher's ultimate goal is to produce medical information beneficial to future patients, the researcher may also be motivated by an interest in improving his professional reputation and research support. Id. at 28; Schneyer, Informed Consent and the Danger of Bias in the Formation of Medical Disclosure Practices, 1976 Wis. L. Rev. 124, 160. These are not improper goals, but they may conflict with a subject's wishes or best interest -- a conflict which the researcher, who has a different focus, may fail to recognize. For example, in the present case, researchers deliberately changed a study protocol -- from a disclosed withdrawal of medication to an undisclosed placebo phase -- to facilitate the recruitment of research subjects, with the effect of depriving the subjects of complete information about the risks of participation. R. 0835.

The dangers posed by investigator conflicts of interest are further illustrated by one of the most infamous federal research projects -- the Tuskegee Syphilis Study.[17/] Over a span of 40

17/ Ruth R. Faden & Tom L. Beauchamp, A History and Theory of Informed Consent 165-67 (1986).

The examples discussed in this brief are only the most infamous of countless examples that could be discussed. A 1966 article by Henry K. Beecher collected 50 cases of research exhibiting ethical violations, in only two of which was it even mentioned that the consent of subjects had been obtained, and in several of which vulnerable or disadvantaged subjects were simply unaware of their participation in research. Henry K. Beecher, Ethics and

years ending in the 1970s, approximately 400 African American males with syphilis, participating in a study conducted by the Public Health Service, were deprived of available treatment so that investigators could determine the long-term health effects of the disease. The participants were not told that they had syphilis or that they were participating in a non-therapeutic experiment. Even worse, the Public Health Service requested that the Army not treat the subjects who were drafted into serving their country during World War II. At least 28 and as many as 100 of the men died of syphilis, and others developed serious syphilis-related heart conditions. James H. Jones, Bad Blood 1-2 (1981). The ensuing outrage over the disclosure of the details of this study ultimately led President Clinton to issue a public apology on behalf of the United States Government to the study survivors and heirs. USA Politics: Apologizing for Tuskegee, Economist, May 19, 1997.

Moreover, researchers often continue to view themselves in the role of doctors treating patients, rather than as investigators conducting a study. Thus, researchers sometimes withhold information they perceive might disturb or harm a subject -- substituting their judgment for that of the subject's, as if they were treating a patient -- rather than objectively informing the subject of potential hazards of proposed

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Clinical Research, 274 New Eng. J. Med. 1354 (1966). In a book published the next year, a different author revealed some 500 academic papers involving unethical experiments. M.H. Pappworth, Human Guinea Pigs (1967).

experiments. As a result, researchers may fail to provide a potential subject with information necessary to assess the risks of an experiment. See also, Rothman, supra, at 56-81. This role confusion more frequently occurs in cases such as this, where the subjects are institutionalized and likely to assume that the physician-researcher is providing treatment; researchers in these circumstances similarly, and mistakenly, tend to approach the subject from the perspective of a treating physician. Id. at 63.

Fundamental confusion between treatment and research is evident in the six federally funded programs before this Court. In every protocol and every consent form available for these experiments, the individuals being studied are referred to as "patients," rather than research "subjects." See, e.g., R. 2194, 2306, 2356. That very label connotes treatment rather than experimental research. This confusion may have resulted in the failure to provide subjects in these studies with information necessary to make an informed decision regarding whether to participate. For example, the effects of complete withdrawal of medication for schizophrenia are downplayed in several studies (see, e.g., R. 1680, R. 2357), while significant, and possibly life-threatening, side effects are not fully explained. Supra Section II.C.1.

The case of the Jewish Chronic Disease Hospital is further evidence that physician-investigator role confusion can result in

a sacrifice of patient autonomy.[18/] In 1963, a physician at the Sloan-Kettering Institute for Cancer Research in New York persuaded the medical director to use hospital patients in a study without the patients' consent. Live cancer cells were injected into patients who were never told the contents of the injections.[19/] The injections offered no therapeutic benefit to the patients. The physicians' view was that "they can go ahead and do anything which they conclude is good for the patient, or which is of benefit experimentally or educationally and is not harmful to the patient, and that the patient's consent is an empty formality." Opinion of the Board of Regents' Discipline Committee, reported in Katz, supra, at 60.

Part of the problem stemmed from the fact that the investigators confused their roles as researchers with their roles as treating physicians. They defended the absence of informed consent on the ground that they were acting as physicians in declining to provide patients with information that would disturb and therefore harm them. The Discipline Committee rejected this defense:

[18/] The account of this incident is taken from Faden & Beauchamp, supra, at 161-62, and documents compiled in Katz, supra, at 9-65.

[19/] The physician-researchers maintained that, because the cells were foreign, the patients would inevitably reject them, and there would be no risk that they would develop cancer. Other physicians who objected to the research suggested that there was, in fact, a risk that patients would develop cancer from the injection or that patients who already had cancer and received the injection would experience a worsening of their existing cancer because their immune systems would be taxed by the injection. Id. at 49, 60.

> [The investigators] overlooked the key fact that so far as this particular experiment was concerned, there was not the usual doctor-patient relationship and, therefore, no basis for the exercise of their usual professional judgment applicable to patient care.

Id. at 61. The Regents recognized that the roles of the physician and the researcher are fundamentally different and make for a dangerous mix in connection with a non-therapeutic research study.

That dangerous mix proved fatal to one patient in an OMH institution. In 1952, a patient voluntarily admitted himself to Defendants' New York State Psychiatric Institute. Without being told that he was being injected with a mescaline derivative provided by the Army Chemical Corps to determine its suitability as a chemical warfare agent (he believed the injections were therapeutic), he agreed for a time to the injections. Barrett v. United States, 660 F. Supp. 1291 (S.D.N.Y. 1987). Before the fourth injection, he objected but was told by his therapist that if he did not continue with the experiment he would be returned to institutions where he had been very unhappy. Id. at 1300. The fifth injection caused Barrett's death. The Army hid its role in the experiments for over 20 years, and OMH contested its own liability. Id. See also GAO, Department of Energy: Information on DOE's Human Tissue Analysis Work 18 (June 19, 1995) (subjects injected with plutonium without their knowledge between 1945 and 1947 to study the effect of plutonium on humans); Mackey v. Procunier, 477 F.2d 877 (9th Cir. 1973) (prisoner administered paralyzing "fright drug" without his

consent in experiment to determine whether instilling fright and inflicting pain would affect behavior).

c. Surrogate Consent Often Disregards The Subject's Intent Or Best Interest

History also teaches that surrogate decision-makers cannot be relied upon to protect the interests of the subject. The Willowbrook State School case illustrates the susceptibility of surrogates to improper pressures when the surrogate is not required to employ any particular criteria in consenting to another's participation in research. See Faden & Beauchamp, supra, at 163-67.

The population of Willowbrook consisted of children with retardation, most of them with severe conditions. The director noted that within six to twelve months of admission, all susceptible children contracted hepatitis, and he began a series of experiments in 1956 to develop a prophylactic agent. The staff deliberately infected with the hepatitis virus new patients whose parents consented in writing. As with the recent examples discussed supra, the consent procedures were inadequate to inform parents of the true nature and risks of the research, or alternatives thereto. In fact, the consent form indicated that the children would receive a vaccine against the virus. Id. at 167. Moreover, the institution coerced parents into providing consent after 1964 by refusing new patients unless their parents consented to the child's participation in the hepatitis study. Paul Ramsey, The Patient as Person: Explorations in Medical Ethics 54 (1970).

Surrogates may also assume, correctly or incorrectly, that their wards will receive better treatment or special privileges at the institution if they participate in desired research. For example, in the 1940s and 1950s, scientists from the Massachusetts Institute of Technology exposed children, some of whom had mental impairments, to radioactive iron or calcium. Letters seeking permission from parents or guardians of potential subjects did not mention the use of a radioisotope, and implied that subjects would benefit nutritionally. The letters also offered additional privileges, including extra milk and additional outings.[20/]

Without appropriate guidelines, surrogates may also be influenced, however subconsciously, by such erroneous considerations as the perception that the patient's continued care is dependent on participation in research, or desperation for a cure even when the research is non-therapeutic.[21/]

Investigators have discovered, in the process of recruiting subjects with psychiatric impairments, "a pattern of family control that discounts the patient's wishes in the decision-

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[20/] Advisory Comm. on Human Radiation Experiments, Final Report 342-47 (1995).

[21/] The American College of Physicians recognizes that surrogates concerned about the welfare of institutionalized patients may be influenced by the fear that refusing research might prejudice the patient's care. Surrogates may also be susceptible to positive inducements to consent, such as better living quarters. American College of Physicians, Cognitively Impaired Subjects, 110 Annals of Internal Med. 843, 846 (1989). See also Barbara A. Weiner, Rights of Institutionalized Persons, in Mentally Disabled and the Law 293 (1985).

making process."[22/] One study has shown that over one-third of surrogate decision-makers not selected by the subject consented to their relative's participation in research despite believing that their relative, if competent, would not have wanted to participate.[23/] Other recent studies also show significant discord between the choices of patients/subjects and proxies not chosen by them.[24/]

It is far easier to decide that someone else should sacrifice for medical advances -- particularly someone who is suffering from dementia or other mental illness -- than to make that choice for oneself. See supra notes 22-24. As Henry Beecher, the author of a landmark article on research abuses, noted:

22/ Richard Ketai et al., Family Influence in the Recruitment of Schizophrenic Research Subjects, 138 Am. J. Psychiatry 351, 351-53 (1981). The authors discovered "striking manipulation" by family members to effect the participation of their schizophrenic relatives in high-risk research. Id. at 351. The authors noted that "[t]his behavior is consistent with previous reports of family members compromising the autonomy of patients with schizophrenia." Id. at 352-53 (citing six studies).

23/ J.W. Warren et al., Informed Consent by Proxy: An Issue in Research with Elderly Patients, 315 New Eng. J. Med. 1124-28 (1986) (the study was one of minimal risk). Moreover, twenty-one percent of those surveyed were persons who would not have consented on their own behalf, but provided consent on behalf of their relative.

24/ Nancy R. Zweibel & Christine K. Cassel, Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies, 29 Gerontologist 615-21 (1989) (of those surveyed, the patient wanted the proxy to make the opposite treatment decision in 24 percent to 50 percent of the hypotheticals put to them; the patient's burden on the family was one of the top criteria for the proxy's decisions).

> Ordinary patients will not knowingly risk their health or their life for the sake of "science." Every experienced clinician knows this. When such risks are taken and a considerable number of patients are involved, it may be assumed that informed consent has not been obtained in all cases. . . . I have worked on the ward of a large hospital for 35 years, [and] I know perfectly well that ward patients will not . . . volunteer for any such use of themselves for experimental purposes when the hazard may be permanent injury or death.

(quoted in Rothman, supra, at 75). As the Appellate Division recognized, the decision to perform a social good by participating in non-therapeutic research of significant risk is a choice that no surrogate can legitimately make for another person, absent clear evidence of the subject's wishes. This is particularly true when dealing with institutionalized patients -- one of the most vulnerable segments of society, and a group which bears a disproportionate amount of the research burden.[25/] The source of the research funding is irrelevant to this basic principle.

[25/] The American Medical Association has determined that institutionalized patients are disproportionately used in research studies and has, in its Code of Medical Ethics, required that physicians refrain from offering incentives to their participation in research: "The overuse of institutionalized persons in research is an unfair distribution of research risks. Participation is coercive and not voluntary if the participant is subjected to powerful incentives and persuasion." American College of Physicians, Code of Medical Ethics, in Codes of Professional Responsibility 237, 276 (Rena A. Gorlin ed. 3d ed. 1994). See also, Final Report, supra, at 785 (in many biomedical experiments between 1944 to 1974 reviewed by the Commission on Human Radiation Experiments, researchers drew from relatively powerless, easily exploited groups including hospitalized adults and institutionalized children).

Just as researchers often perceive themselves as care-giving physicians, even when engaged in research, so too do others misconceive the role of the researcher, and are predisposed to view the research as serving the therapeutic interest of the subjects.[26/] This tendency, known as "therapeutic misconception," undermines the ability of the surrogate to evaluate objectively the nature and risks of the research. Especially in an institutionalized setting, subjects and surrogates are likely to assume that the research procedures are intended to benefit the subjects or at least not to cause them harm, even when told otherwise. For example, one subject who consented to non-therapeutic research that could have caused severe liver damage explained why he joined by stating, "Doctor, we know you wouldn't hurt us, and anyway the hospital wouldn't let you." Paul S. Appelbaum et al., Informed Consent: Legal Theory and Clinical Practice 251 (1987) (citing J.C. Garnham, Some Observations On Informed Consent In Non-Therapeutic Research, 1 J. Med. Ethics 138-45 (1975)).

d. The Weight Of Medical And Legal Authority Endorses The Protections Adopted In The Appellate Division Opinion

Respected members of the medical community agree with the Appellate Division's view that risky, non-therapeutic research should never be performed on incapable patients whose wishes are

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[26/] Michael Bamberg & Nancy Budwig, Therapeutic Misconceptions: When the Voices of Caring and Research are Misconstrued as the Voice of Caring, 2 Ethics & Behavior 165-84 (1992); Final Report, supra note 20, at 761.

unknown. See, e.g., Ramsey, supra, at 14 (research should never involve incompetent persons if it does not hold out the prospect of direct benefit to the individuals on whom the research is conducted) (the book is based on the Lyman Beecher Lectures that Ramsey delivered at the Divinity School and the School of Medicine of Yale University). The British Medical Research Council takes the same view: "when true consent cannot be obtained, procedures which are of no direct benefit and which might carry a risk of harm to the subject should not be undertaken." I.G. Pryce, Clinical Research Upon Mentally Ill Subjects Who Cannot Give Informed Consent, 132 Brit. J. Psychiatry 366, 366 (1978).[27/] Surrogate consent is only permitted in the United Kingdom for experimental procedures leading to a possible benefit to the patient. Id. See also infra Section II.D.1.

Legal and political bodies have come to a similar conclusion on this issue. For example, the American Bar Association's Commission on the Mentally Disabled (now known as the Commission on Mental and Physical Disability Law) has taken the position that non-therapeutic research on institutionalized persons with

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[27/] The UK Medical Research Council, established in 1913, is funded mainly by the government of the United Kingdom. It has created its own research institutes, including the National Institute for Medical Research (which includes Applied Psychology and Child Psychiatry Units and Initiatives for AIDS and HIV), that are responsible for numerous, dramatic advances in research: discovery of a method of production of artificial hemoglobin in 1992, discovery of the gene for Huntington's disease in 1993, and discovery of a drug therapy for AIDS sufferers in 1995. MRC Home Page (http://www.mrc.ac.uk/home.html).

mental disabilities should involve no more than minimal risk to the health or well-being of the subject. "Irreversible effects are not 'minimal.'" Statement of ABA Commission on the Mentally Disabled Before National Human Experimentation Group, 1 Mental Disability L. Rep. 155, 156 (1976). The International Covenant on Civil and Political Rights prohibits any medical or scientific experimentation that may be detrimental to the health of anyone involuntarily detained in psychiatric hospitals. The Nuremberg Code, adopted in 1947 by the United States military tribunal sitting in judgment on the Nazi's atrocities, prohibits any biomedical research on subjects who are not competent. Katz, supra, at 305.

e. Oversight By Institutional Review Boards Does Not Cure The Deficiencies In Federally Funded Research

Under the federal regulations, IRBs are charged with the responsibility of overseeing federally funded research involving human subjects. 46 C.F.R. §§ 107-117. Unfortunately, this system does not adequately protect the rights of individuals with mental disabilities who consent to participate in research.

(1) IRBs Do Not Effectively Monitor The Consent Process

Some scholars fault the federal regulations for "plac[ing] primary responsibility for obtaining informed consent on the principal investigator," thereby creating inherent conflicts of interest that are not monitored by the IRBs. Richard Delgado & Helen Leskovac, Informed Consent in Human Experimentation: Bridging the Gap Between Ethical Thought and Current Practice, 34

UCLA L. Rev. 67, 75, 91-107 (Oct. 1986). Despite their regulatory authority to "observe or have a third party observe the consent process," § 46.109(e), IRBs fulfill this requirement in practice by simply reviewing the informed consent form prepared by the investigator. GAO Report at 11; Jesse A. Goldner, An Overview of Legal Controls of Human Experimentation and the Regulatory Implications of Taking Professor Katz Seriously, 38 St. Louis L.J. 63, 132 (1993) (citing John A. Robertson, Taking Consent Seriously: IRB Intervention in the Consent Process, 4 I.R.B. 1 (May 1982)).

IRB oversight of the informed consent process is almost exclusively dedicated to examining consent forms in an effort to make them more understandable. Hearing on Biomedical Ethics, May 8, 1997, Testimony of Dr. Caplan. Even with this limited goal, IRBs spend no time ensuring that the changes they mandate are actually implemented by the researcher, or that the contents of the forms are adequately explained to potential subjects. Id.;[28/] GAO Report at 11.

Significant time constraints have most likely contributed to the IRBs' failure to develop any system for monitoring the consent process. University IRBs sometimes review up to 200

[28/] An individual who spent four years as an IRB member described this absence of monitoring as a structural weakness, noting that her IRB had "no mechanism for assuring compliance with its [changes to the informed consent form]. For all we knew, researchers were ignoring our indicated amendments." Bartolo, Tales of Informed Consent: Four Years On An Institutional Review Board, 2 Health Matrix: J. of Law-Med. 193, 229 (Summer 1992).

research protocols in a single meeting, spending no more than a minute or two on each. GAO Report at 17. These organizations have no means for determining whether information is conveyed to potential subjects and whether the subject understands the risks and benefits (if any) of the proposed research.

Moreover, the federal regulations make no provision for the more difficult process of ensuring that informed consent is obtained from institutionalized subjects with mental disabilities, or their legally authorized representative. Hearing on Biomedical Ethics Before the Human Resources & Intergovernmental Relations Subcomm. of the House Government Reform and Oversight Comm., 105th Cong. (1997) ("Biomedical Ethics Hearing") (statement of Rep. Shays). This omission is particularly dangerous because the problem of therapeutic misconception is most acute where research involves persons with mental disabilities: Owing to their heavy dependence on the public mental health system, persons with mental disabilities frequently rely on research protocols for access to promising new medications, not realizing that many experiments provide no benefit to them.[29/]

[29/] Biomedical Ethics Hearing (statement of Laurie Flynn, National Alliance of the Mentally Ill). See also Section II.C.2, supra (examples of inadequate consent procedures including the UCLA schizophrenia study, where the IRB did not exercise sufficient oversight of the process of obtaining informed consent from subjects with mental disabilities).

(2) Conflicts Of Interest Also Interfere With Effective IRB Oversight

IRBs, like the investigators themselves, are beset by conflicts of interest. Although IRBs were designed to be "the front line in safeguarding human subjects," Plain Dealer, January 23, 1997, in reality they are often beholden to two other significant constituents -- the investigator and the institution. Dale L. Moore, Recurrent Issues in the Review of Medical Research on Human Subjects, 1 Alb. L.J. Sci & Tech. 1, 12 (1991). Indeed, their supposed independence is often hampered by "close collegial ties with researchers at the institution." GAO Report at 18. Moreover, the regulations only require that one of the five or more IRB members not be affiliated with the institution. 45 C.F.R. § 46.107(d).

The requirement that IRBs be composed of members with "varying backgrounds," id. § 46.107(a), has not ensured the intended diversity, as the Boards are typically dominated by biomedical and behavioral researchers -- individuals prone to put scientific progress ahead of the interests of research subjects. Goldner, supra, at 106. Mildred K. Cho & Paul Billings, Conflict of Interest and Institutional Review Boards, 45 J. Investigative Med., 154, 155 (Apr. 1997). An IRB's independence may also be compromised by pressure from institutional officials to attract funding and the institution's financial ties to the study. GAO Report at 18. The GAO even uncovered examples of IRB members participating in review of their own studies. Id. at 13. In these circumstances, IRBs cannot serve as an effective

counterweight to the bias of the investigator, who may naturally, though unintentionally, put his or her own interests above those of the research subjects.

As a result of time constraints, conflicts of interest and other pressures, IRBs have not performed the critical task for which they were created: protecting the rights of human subjects of medical research. See GAO Report at 15-16 (OPRR, citing violations of informed consent rules, suspended several institutions' authority to conduct further research until IRB deficiencies are cured).

D. Defendants' Argument Below, Predicting The Decline Of Medical Progress, Is Without Merit

1. The Use of Advance Directives And Court Approval Protect Subjects' Rights Without Threatening Legitimate Research

As the preceding sections demonstrate, researchers and surrogates often act, despite noble purposes and good intentions, without careful consideration of the potential subject's preferences or best interest. The use of advance directives -- documents executed at a time when individuals are capable of consenting, and that outline the parameters of their willingness to participate in research -- address the problems inherent in permitting researchers to obtain surrogate consent without objective criteria as guidance. Indeed, the Appellate Division endorsed this approach, and prohibited surrogate consent to non-therapeutic research of greater than minimal risk on subjects incapable of consenting absent either an advance directive or selection of a specific surrogate while capable. Op. at *2. The

same approach is equally appropriate in the context of federally funded research.

Defendants cry wolf when they suggest that society will not be able to cure serious diseases, such as AIDS and Alzheimer's, without surrogate consent to the use of institutionalized subjects. Similarly dire warnings have issued each time, over the last 50 years, that additional research restrictions have been imposed to protect the rights of subjects -- yet research funds and accomplishments continue to advance. See, e.g., Maurice B. Visscher, Animal-Care Legislation: Why Scientists Do Object, 151 Science 636 (Feb. 11, 1966) (stating that if passed, the Animal Welfare Act "would delay or prevent scientific discovery, [and] cause deterioration in medical and other biological education"). In fact, many claimed that early efforts to require informed consent and IRBs would hamper research. See John A. Robertson, The Law of Institutional Review Boards, 26 UCLA Law Rev. 484, 516 n.172 (1979) (citing an early survey in which a substantial majority of investigators felt that the IRB procedure "impeded research"); William J. Turner, Laws as Uncontrolled Experiments on Society, Psychiatric J. of Univ. of Ottawa 47, 49 (1974) (dramatically claiming that NIH draft proposals requiring review committees and informed consent would halt research completely); Audre E. Hellegers, Problems in Bioethics: Medical Research Commission, Ob. Gyn. News 12 (Apr. 15, 1975) ("Reactions to the early drafts of the proposed HEW [now HHS] guidelines for research sometimes came close to panic.

Some even went so far as to suggest that a cure to cancer would never be found if such restrictions were to be placed on science.").

The type of research subjects sought for the six federally funded programs at issue in this appeal would be capable, at some point, of providing an advance directive specifying their views on participation in research. All six of the federally funded programs involve subjects who suffer from schizophrenia or Alzheimer's disease. Most people with chronic mental illnesses such as schizophrenia experience periods of remission from their illnesses; consent to research can thus readily be obtained from these patients when their illnesses are in remission. R. 2876 (Stastny Affidavit). Similarly, Alzheimer's patients typically know of their illness well in advance of the stage where their illness renders them incapable of consenting to research. As the Chair of the IRB for the National Institutes of Mental Health ("NIMH") has explained, patients diagnosed with Alzheimer's typically learn of their disease long before they are rendered incapable, and are thus "classic examples" of individuals for whom advance directives are ideally suited. Trey Sunderland and Ruth Dukoff, Informed Consent with Cognitively Impaired Patients: An NIMH Perspective on the Durable Power of Attorney, 4 Accountability in Research 217, 224-25 (1996); Accord Supreme Court Opinion at n.3, R. 27; R. 2875-77 (Stastny Affidavit).

Moreover, many states, as well as the United Kingdom, have for years imposed restrictions on the types of research that can

be performed with incapable subjects, and restrictions on surrogate consent to that research, yet there has been no evidence of the predicted downfall of scientific progress. See Section II.D, infra. It is indeed odd for Defendants to suggest that Plaintiffs (themselves diagnosed with mental illness), or the undersigned (devoted to the rights and interests of such individuals),[30/] are somehow enemies of medical progress to cure mental illness. Plaintiffs and the undersigned seek only to ensure that the cause of scientific progress is not used as a weapon to trample the rights of individuals with mental illness -- particularly where, as here, the two interests can be so readily reconciled.

It makes no sense to suggest, as Defendants and their Amici do, that progress in finding the cures for AIDS and Alzheimer's disease will grind to a halt without the ability to obtain surrogate consent to use incapable subjects in non-therapeutic research. Brief of Amici to the Appellate Division at 6. As earlier noted (see supra note 27), the UK National Institute for Medical Research has made several recent significant research advances, despite a complete bar on non-therapeutic research on individuals incapable of giving informed consent. The use of advance directives, as required by the Appellate Division, and as applied to therapeutic and federally funded research, will

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30/ See Affirmation in Support of Motion for Leave to Appear as Amici Curiae (Appendix hereto) for a description of Amici, many of whom advocate research into the causes/cures of mental disabilities and AIDS.

provide ample latitude for continued research on mental and other illness.

The National Institutes of Health ("NIH") has successfully used advance directives since 1985 to obtain consent for participation in research. Sunderland & Dukoff, supra, at 221. Even after their illnesses render the subjects incapable, their continued assent to research is solicited, and any objection by the subject is honored. Id. at 223-24. Such use of advance directives has not hindered NIH research into Alzheimer's or other dementia-related illnesses. In 1976, prior to the use of advance directives, the budget for the NIH's National Institute on Aging ("NIA") was $19.2 million. Evan DeRenzo, Surrogate Decision Making for Severely Cognitively Impaired Research Subjects: The Continuing Debate, 3 Cambridge Q. of Healthcare Ethics 539 (1994). By 1986, just after advance directives were first employed, the budget was $150.9 million. Id. Eight years into the use of advance directives, NIA received $420 million, with half of those funds designated for Alzheimer's research and other dementia-related conditions. Two other NIH agencies received an additional $75 million that year for similar research. Id. Despite federal budgetary constraints, NIA is slated to receive $495 million in 1998. Budget of the United States Government, Fiscal Year 1998, Appendix at 504.

Defendants' only argument below against the use of advance directives was that OMH cannot always predict in advance what subjects will be suitable for future research projects. Def.

Brief to the Appellate Division at 40. While that may be true, it is not an argument against the use of advance directives, but rather an argument for obtaining them from all patients willing to execute such directives, so that their research wishes will be known and respected. Defendants cannot justify the surrogate shopping and unfettered discretion accorded to surrogates, permitted by the OMH regulations, when potential research subjects could be asked to state their wishes at a time when they are capable of providing informed consent.

A number of groups within the medical community have also rejected Defendants' position, and advocate the use of advance directives. The American College of Physicians takes the position that, in the absence of an advance directive, surrogates should not be permitted to consent on behalf of cognitively impaired subjects to non-therapeutic research that presents more than a minimal risk of harm or discomfort. American College of Physicians, Cognitively Impaired Subjects, 111 Annals of Internal Med. 843, 844 (1989). Moreover, the College believes that, in the absence of a clear directive from the subject, surrogates should always be governed, in deciding whether to enroll the subject in therapeutic research, by what is in the incompetent person's best interest. Id. at 845. Following these guidelines will protect the needs of both the subject and the research community -- it "will allow progress in research without violating society's obligation to uphold the rights and protect the welfare of potential experimental subjects." Id. at 843.

Other prominent physicians and legal analysts in the United States and abroad agree. See Zweibel (Director of Research and Geriatrics and Gerontology, University of Chicago Department of Medicine) & Cassel (Chief of Section of General Internal Medicine, University of Chicago Department of Medicine), supra, at 620 ("The findings [on surrogate decision-making] support the importance of advance directives as necessary for ensuring patient autonomy . . . ."); G.J. Annas, J.D., M.P.H., L.H. Glantz, J.D. (Boston University Schools of Medicine and Public Health), Rules for Research in Nursing Homes, 315 N. Eng. J. Med. 1157 (1986) (research with incompetent subjects should be related to a problem unique to this population and should involve either no or minimal risk; surrogates should never volunteer another for non-therapeutic experimentation that carries any risk of harm absent specific prior instructions from the subject).

Thus, the relief sought by Plaintiffs in federally funded programs is neither new nor radical. Both the medical and legal communities recognize that substantial safeguards are necessary to protect institutionalized persons with mental illness, who are disproportionately used in the conduct of experimental research. The Appellate Division realized that such safeguards include a prohibition on the conduct of non-therapeutic research on institutionalized patients with mental illnesses in the absence of a prior express indication of their wishes.

Even if, as Defendants suggest, the progress of science is more measured as a result of more stringent regulation -- a

proposition contrary to the weight of the evidence -- that is a price we must pay. Society cannot choose to make human guinea pigs of our most vulnerable citizens.

2. Many Other States Employ Procedures For Obtaining Informed Consent As Restrictive As Those Required By The Appellate Division, And Research Nonetheless Thrives

a. Many States Successfully Prohibit Non-Therapeutic Research On Subjects Incapable Of Providing Informed Consent

Many states have legislation or regulations prohibiting non-therapeutic research on subjects incapable of consent, and which are thus equally if not more restrictive than the requirements imposed by the Appellate Division.[31/] See also Section

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[31/] See, e.g., Alaska Stat. § 13.26.150 (Michie 1996) (a guardian may not consent to participation in a medical experiment not intended to preserve the life or prevent serious impairment of the physical health of the ward); Alaska Stat. § 47.30.830(a) (Michie 1996) ("Experimental treatments involving any significant risk of physical or psychological harm may not be administered to a patient."); Cal. Prob. Code § 2354 (West 1991) (conservator of subject incapable of giving consent may seek treatment only in good faith based on medical advice when necessary); Conn. Gen. Stat. Ann. § 45a-677 (West 1993) (limited guardian, who may be assigned by court to consent to medical care for persons with mental disabilities, may only consent to experimental biomedical experiment or procedure if intended to preserve life, prevent serious physical impairment or assist in regaining ward's abilities); Del. Code Ann. tit. 16, § 5172(b)(1)-(2) (1995) (no patient may be approached to participate in pharmaceutical research if incapable of voluntary consent); Fla. Stat. Ann. § 393.13 (West 1993 & Supp. 1997) (guardian of persons with developmental disabilities may provide informed consent to "experimental medical treatment" or "necessary surgical procedure," but treatment programs involving the use of noxious or painful stimuli prohibited); 405 Ill. Comp. Stat 5/2-110 (West 1993) (guardian may only consent to experimental treatment in the best interest of the ward); Mass. Regs. Code tit. 104 § 13.01-.05 (1995) (research on patients in mental

II.D.2.b, infra.

Yet despite the more restrictive elements of these regulations, Amici are unaware of any complaints about resulting or notable declines in essential research that requires the use of incapable subjects. In fact, several states with the greatest restrictions on research, and which ban all non-therapeutic research of greater than minimal risk on subjects deemed incapable of consent, receive some of the largest research grants from the National Institutes of Mental Health ("NIMH"). California, which only permits a conservator's consent for treatment when based on medical advice that it is necessary, received the highest grant from NIMH in 1996 -- more than $82.6 million. National Institute of Mental Health Research

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facilities that will not provide direct, therapeutic benefit not permitted; research on patients with mental disabilities where risk is more than minimal and exceeds the benefit to the subject is prohibited); Mo. Ann. Stat. § 630.115, § 630.192 (West Supp. 1997) (involuntarily committed patients with mental disabilities may not be subjected to experimental research; biomedical or pharmacological research of no direct therapeutic benefit prohibited on patients with mental disabilities); N.J. Stat. Ann. § 30:4-24.2 (West 1997) ("Under no circumstances may a patient in treatment be subjected to experimental research which is not directly related to the specific goals of his treatment program.") (provision governing the rights of patients generally); N.J. Stat. Ann. § 30:6D-5 (West 1981) ("Under no circumstances may a person in treatment be subjected to hazardous or intrusive experimental research which is not directly related to the specific goals of his treatment program") (provision governing the rights of persons with mental disabilities); 12 Va. Admin. Code 5-20-40 (Michie 1992) ("Nontherapeutic research using patients or residents within an institution as defined herein is forbidden unless it is determined by the research review committee that such nontherapeutic research will not present greater than minimal risk.").

Information Sourcebook -- Extramural Research (1996). Massachusetts, Illinois and Connecticut, which similarly restrict research on incapable subjects, ranked fourth, seventh and eighth, respectively, in the size of their NIMH grants in 1996 ($30 million, $15.8 million and $14.6 million, respectively). Id. These states have been similarly ranked in the size of their NIMH research grants since 1986. Id.

These funds have been used to make substantive progress in the cure of diseases such as Alzheimer's and schizophrenia, notwithstanding the same type of research restrictions adopted by the Appellate Division. See, e.g., Sertindole Shows Promise in Schizophrenia, Business Wire (May 8, 1996) (California study testing new schizophrenia drug); Stephen R. Marder, New Antipsychotics--Clinical Trials and Follow-up, Abstract at http://cos.gdb.org/best/fedfund/nih-states/ca-hmtl (California) (requesting continued federal funding of a double-blind comparison of schizophrenia drugs Clozapine, Risperidone and others); Alan I. Green, Clozapine or Haloperidol in First Episode Schizophrenia, Abstract found at http://cos.gdb.org/best/fedfund/nih-states/ma.hmtl (Massachusetts) (application for NIH funding for study comparing clinical effects of two schizophrenia drugs); Gina Kolata, Landmark in Alzheimer Research: Breeding Mice with the Disease, N.Y. Times, Feb. 9, 1995, at A20 (California researchers create laboratory mice with Alzheimer's disease, which will speed research).

b. Many States, Like New York, Require Court Approval Before Administering Psychotropic Medications To Patients Incapable of Consent Or Approving Therapeutic Research

Like New York (Rivers v. Katz), many other states require court approval even in cases of therapeutic treatment that carries a greater than minimal risk. These states recognize, as did the Appellate Division, that court approval is necessary to protect the interests of the research subject even when the project has the potential to directly benefit the patient.[32/]

[32/] See, e.g., Alaska Stat. § 47.30.836 (Michie 1996) (court approval required prior to administration of psychotropic medication not in an emergency to a patient incapable of providing informed consent); Idaho Code § 66-405 (1995) (court approval required before guardian may consent to "experimental surgery, procedures, or medications"); 405 Ill Comp. Stat. 5/2-110 (West 1993) (court approval required before guardian may consent to "unusual, hazardous or experimental services or psychosurgery" in the best interest of the ward); Minn. Stat. § 525.56 (1992) (court approval required for guardian consent to "experimental treatment of any kind"; court must find by clear and convincing evidence that treatment is in best interest of the ward, evaluating the risks of the procedure, whether less restrictive treatment is available, and the recommendation of the commissioner of human services); Nev. Rev. Stat. Ann. § 159.0805 (Michie 1993) (guardian must have court approval to consent to "experimental medical treatment" of the ward); N.H. Rev. Stat. Ann. § 463.12, § 464-A:25 (1995) (guardian must have court approval to consent to "experimental treatment of any kind" for minor or incapacitated person); N.D. Cent. Code § 30.1-28-12 (1995) (no guardian consent to "experimental treatment of any kind" without court approval); 20 Pa. Cons. Stat. Ann. § 5100.54(VI)(2)(b), 5521 (West 1995) (no guardian consent to participation in any biomedical or behavioral experiment or "experimental treatments involving any risk to the patient" without court approval); N.H. Rev. Stat. Ann. § 464-A:25(I)(c)-(e) (1995) (no guardian may consent, without court approval, to "experimental treatment of any kind," which may be approved only if in the best interest of the ward); S.D. Codified Laws § 27A-12-3.20 (Michie Supp. 1996) (no experimental research on persons incapable of consenting without court order).

No less can be required when the research offers no potential therapeutic benefit to the subjects.

The New York state law is no more restrictive than the statutes and regulations passed by numerous other states, and provides an appropriate check on the potential conflict of interest and abuse that can otherwise occur, without any apparent detrimental impact on the progress of science.

III. Conclusion

A civilized society cannot allow individuals with mental disabilities to be used as guinea pigs in risky experiments which offer no possible benefit to the subjects, and only a speculative future benefit to others. Both the New York and United States constitutions, as well as New York common law, prohibit such a result -- regardless of whether it is paid for by state or federal dollars. We respectfully ask this Court to so declare.

Respectfully submitted,

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S T A T E O F N E W Y O R K
C O U R T O F A P P E A L S

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Plaintiffs-Appellants,

-against-

THE NEW YORK STATE OFFICE OF MENTAL HEALTH, RICHARD C. SURLES, as Commissioner of the New York State Office of Mental Health and MARK R. CHASSIN as Commissioner of the New York State Department of Health,

Defendants-Respondents.

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S T A T E O F N E W Y O R K
C O U R T O F A P P E A L S

T.D., M.P., M.T., N.V., G.P., M.C. and NEW YORK LAWYERS FOR THE PUBLIC INTEREST, INC., DISABILITY ADVOCATES, INC. and MARVIN BERNSTEIN as Director of Mental Hygiene Legal Service, First Department, on behalf of all patients in facilities operated or licensed by the New York State Office of Mental Health,

Plaintiffs-Appellants,

-against-

THE NEW YORK STATE OFFICE OF MENTAL HEALTH, RICHARD C. SURLES, as Commissioner of the New York State Office of Mental Health and MARK R. CHASSIN as Commissioner of the New York State Department of Health,

Defendants-Respondents.

BRIEF OF DEFENDANTS-RESPONDENTS

PRELIMINARY STATEMENT

This is an appeal, by leave of this Court, from a decision and order of the Appellate Division, First Department, dated December 5, 1996 (Ross, J.), which (1) invalidated regulations promulgated by the Office of Mental Health ("OMH") for the conduct of human subject research involving residents of state mental health facilities, and (2) in the manner of an advisory opinion, set forth a view of the State and federal constitutions and the common law to guide the Commissioner of Health in the event that she should decide to issue regulations on that same

subject at some future date.

Plaintiffs-Appellants ("Plaintiffs") -- OMH facility residents and several mental health advocacy groups[1] -- argue on appeal that the dicta contained in the advisory portion of the Appellate Division's decision should be extended by this Court to apply to all human subject research involving minors or incapable adults at all OMH licensed or operated facilities. Defendants-Respondents ("Defendants") -- the New York State Office of Mental Health ("OMH") and its Commissioner, and the Commissioner of the New York State Department of Health ("DOH")[2] -- contend, however, that this Court should decline to extend the analysis as requested.

QUESTIONS PRESENTED

1. Whether this Court should extend the constitutional analysis of the Appellate Division, issued as an advisory opinion, to guide the possible future enactment of research regulations by the Commissioner of Health?

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[1] Plaintiffs include six adults who are involuntarily committed to OMH facilities, and have been medicated with FDA-approved drugs over objection according to the procedure outlined by this Court in Rivers v. Katz, 67 N.Y.2d 485 (1986). (A. 8). Plaintiffs New York Lawyers for the Public Interest, Inc., Disability Advocates, Inc. and Mental Hygiene Legal Service, First Department are non-profit corporations established under federal or state law to bring suit on behalf of the institutionalized mentally ill. 42 U.S.C. § 10905(a); Mental Hygiene Law § 47.03; (R. 23-24).

[2] In 1995, James Stone was appointed Commissioner of the Office of Mental Health, and Dr. Barbara A. DeBuono was named the Commissioner of the Department of Health.

2. Whether this Court should extend the Appellate Division's advisory opinion when that opinion ignores existing due process protections afforded to patients under State statute and federal regulations, including detailed informed consent requirements, patient notification, and the observance of a patient's verbal or demonstrable objection?

BACKGROUND

Responsible, controlled, and regulated human subject research has long been considered essential to scientific progress toward the development of safer and more effective treatments for a variety of illnesses previously considered untreatable or incurable. As Supreme Court noted (R. 22):

> In recent years, researchers have made amazing advances in psychotropic drugs, neurobiology, genetic studies, and the like, with the promise of more to come . . . . Not all experiments can be restricted to laboratory animals. There comes a time, before a new treatment can be accepted, when there must be an assessment of controlled experiments with human beings.

As Plaintiffs have observed, this case raises issues of "paramount importance to patients in psychiatric facilities," (Pl. Br. p. 1), many of whom suffer from precisely the types of maladies addressed by past and current human subject research. Accordingly, as a prelude to examination of the history of this litigation and the legal issues raised on this appeal, it is essential to explore the parameters of human subject research as

it actually occurs in OMH facilities and as reflected by the Record, without the emotionally-charged language and medical inaccuracies that pervade Plaintiffs' brief. This requires, at a minimum, a brief discussion of the statutory and regulatory environment, a definition of terms and the details of the ten research protocols, or projects, specifically at issue in this case.

The Regulatory Environment

Enacted in 1975, Public Health Law ("PHL") Art. 24-A protects human subjects in research conducted in New York State, including research conducted in or by any State agency. See PHL Art. 24-A. Recognizing the importance of human subject research to scientific advancement and concerned about past abuses, the Legislature articulated the State's "vital concern" in "safeguarding the rights and welfare of individual human subjects in the conduct of these human research projects." PHL § 2440. Article 24-A is thus designed to protect human subjects against risks of unnecessary pain, suffering, or injury. Id. In addition to the statutory protections afforded, Section 2446 also empowers the Commissioner of Health to promulgate rules and regulations as necessary to effectuate the Article. PHL § 2446.

Following extensive study and reporting by a Presidential Commission on human subject research, the United States Department of Health and Human Services ("HHS") also promulgated

a comprehensive regulatory scheme governing human subject research funded by the federal government. See 45 C.F.R. Part 46; see also U.S. General Accounting Office, "Scientific Research: Continued Vigilance Critical to Protecting Human Subjects," Report to the Ranking Minority Committee on Governmental Affairs U.S. Senate, at 2 (March 1996) ("Today's oversight of tens of thousands of HHS-funded research and FDA-related drug studies appears to have reduced the likelihood that serious abuses of human subjects, comparable to past tragic events, will occur"). Recognizing the protections applicable to federally funded programs, the Legislature expressly excluded such programs from the scope of Article 24-A. See PHL § 2445.[3]

Article 24-A and the federal regulations afford human research subjects numerous and substantial protections. For example, PHL § 2444(3) prohibits inclusion of, inter alia, minors and incapable adults in research studies absent consent from the Commissioner of Health and an independent human subject research review committee; 45 C.F.R. § 46.102(c) recognizes surrogate

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[3] PHL § 2445 provides as follows: "The provisions of this article shall not apply to the conduct of human research which is subject to, and which is in compliance with, policies and regulations promulgated by any agency of the federal government for the protection of human subjects." See also L. 1975, ch. 450, 1975 Legislative Annual, at 274-75 (recognizing need to prohibit involuntary testing, and acknowledging past unethical research studies, legislation excludes federally-funded studies because federal regulations already "cover those situations where federal funds are involved") (Mem. of A. Hevesi).

consent only to the extent it exists under State law. In addition, both Article 24-A and the federal regulations impose qualifications requirements on researchers and/or Institutional Review Board ("IRB") members, (PHL §§ 2441(6), 2444; 45 C.F.R. § 46.107(a)), and both impose similar notice and informed consent requirements on all researchers. Finally, both require explicit notice to the subject that they may withdraw from a research study at any time without prejudice. See PHL § 2441(5)(f); 45 C.F.R. § 46.116(a)(8). Plaintiffs do not assert that either Article 24-A or the federal regulations are unlawful or constitutionally infirm.

In 1990, OMH also promulgated regulations governing human subject research at OMH operated or licensed facilities, designed to protect patients who participate in research and to facilitate research designed to address the mental disorders from which they suffer. See 14 N.Y.C.R.R. § 527.10. At the time these regulations were promulgated, DOH and OMH took the view that the agencies shared regulatory jurisdiction over human subject research into mental illness. (R. 2733) (Millock Aff.). In addition, pursuant to an assurance executed by the federal government and OMH, all research at OMH operated or licensed facilities complied with the HHS's federal regulations, including reporting requirements. Thus, human subject research at OMH operated or licensed facilites was subject to at least three different regulatory schemes: those of DOH (pursuant to Art. 24-

A), OMH, and HHS.

Definitions

Human subject research involves medical, psychiatric and psychological components that cannot be neatly classified. The Appellate Division's analysis, however, forces those components into one of two categories, therapeutic or non-therapeutic, which require definition. "Therapeutic" research generally refers to studies, most often involving FDA-approved drugs that are being applied in new contexts or new therapeutic agents in late-phase clinical trials,[4] that hold out the prospect of direct benefit to

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[4] The FDA approves this practice, which is known as "off-label" prescribing:

> The [Food, Drug and Cosmetic] Act does not, however, limit the manner in which a physician may use an approved drug. Once a product has been approved for marketing, a physician may prescribe it for uses or in treatment regimens or patient populations that are not included in approved labeling. Such "unapproved" or more precisely, "unlabeled" uses may be appropriate and rational in certain circumstances, and may, in fact, reflect approaches to drug therapy that have been extensively reported in medical literature.
>
> The term "unapproved uses" is, to some extent, misleading. It includes a variety of situations ranging from unstudied to thoroughly investigated drug uses. Valid new uses for drugs already on the market are often first discovered through serendipitous observations and therapeutic innovations, subsequently confirmed by well-planned and executed clinical investigations. Before such advances can be added to the approved labeling, however, data substantiating the effectiveness of a new use or regimen must be submitted by the manufacturer to FDA for evaluation.

FDA, "Use of Approved Drugs for Unlabeled Indications," talk paper released on September 28, 1982 (emphasis added). See also 21 C.F.R. Part 312 Subpart D (extensive FDA oversight and

the research subject.[5] In fact, several important medical and psychiatric developments can be traced to human subject research studies conducted at, inter alia, OMH operated or licensed facilities.[6]

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reporting requirements for clinical trials of investigational new drugs); id. § 312.3(b) (an investigational new drug is "a new drug, antibiotic drug, or biological drug that is used in clinical investigation"); K. Tuthill, "Human Experimentation: Protecting Patient Autonomy Through Informed Consent," 18 J. Legal Med. 221, 223 (June 1997) ("After drugs are proven safe and effective, the testing moves to Phase III . . . . Although the drugs still are classified technically as experimental and may not be approved by the FDA for several years, the drugs are considered safe").

[5] The term "possibly therapeutic," coined by Plaintiffs, has no basis in actual human subject research. The notion that such a category even exists is spurious, given that all forms of medical treatment, let alone therapeutic research, present only the possibility that the services will benefit the patient. "Possibly therapeutic" research is, in fact, therapeutic research. See National Bioethics Advisory Commission, Human Subjects Subcommittee, at 235 (Sept. 18, 1997) ("If there is a possibility of benefitting the health and well-being of the individual then it is in that category of possibly therapeutic") (Testimony of Ruth Lowenkron).

[6] See, e.g., James Miller, "Eli Lilly Study of Zyprexa Drug Challenged by J&J," Dec. 13, 1996, Wall St. J., at B2 (human subject research on 339 schizophrenic patients contributed to 10/96 FDA approval of drug); Peter D. Kramer, Listening to Prozac 60-66 (1993) (describing the research process leading to the development of fluoxetine hydrochloride (Prozac)); Beasley, Tollefson, and Tran, "Efficacy of Olanzapine: An Overview of Pivotal Clinical Trials," Journal of Clinical Psychiatry, 58 Suppl. 10:7-12 (1997)(clinical trials leading to approval of Olanzapine/Zyprexa); Meyer and Simpson, "From Chlorpromazine to Olanzapine: A Brief History of Antipsychotics," Psychiatric Services, vol. 48, no. 9, at 1137-1139 (Sept. 1997); Physician's Desktop Reference 935-40 (51st ed. 1990)(publication of FDA approved package inserts which include discussion of results from chemical trials of Prozac on which approval and labeling are based); id. at 2377-81 (same for clozapine); id. at 1348-52 (same for risperdal).

By contrast, the term "non-therapeutic" is not as susceptible of definition, because in reality, research studies cannot be unbundled to remove all aspects that may not be directly beneficial, but which are diagnostic or facilitate accurate monitoring. According to the Stipulation entered into by the parties on February 9, 1996 (R. 2909), "[i]f any greater than minimal risk element of an experiment is 'non-therapeutic' . . . the entire experiment is deemed 'non-therapeutic,' unless all greater than minimal risk, non-therapeutic elements are eliminated from the experiment." (R. 2910). Under the Stipulation, a therapeutic research study can thus be rendered "non-therapeutic" if a standard medical procedure involves more than minimal risk and does not provide a direct benefit -- for example, a venipuncture to draw blood for monitoring purposes. See R. 2570 (Delano Aff.) ("Minimal risk is such a low threshold that IRBs have classified protocols as involving more than minimal risk because of such procedures as venipuncture or skin punch biopsy"). Using this definition, Plaintiffs argue that nine of the ten protocols at issue in this case are "non-therapeutic," although each one holds out the prospect of benefit to the research subject, but involves some "non-therapeutic" element, which the Plaintiffs leave undefined in each case. See infra at 14-24.

The term "capacity"[7] refers to the patient's ability to understand the purpose, nature, risks, benefits and alternatives of proposed medical treatment and to participate in making treatment decisions.[8] Thus, a person who may be judicially found incompetent and is involuntarily committed to a State OMH

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[7] Institutional Review Boards ("IRB") exist in every institution where human subject research is performed:

> IRBs review, evaluate, and approve or disapprove investigations that include human research subjects. The responsibility is filled in several ways. First, the IRB ensures that risks to subjects are minimized by scrutinizing research procedures. Second, the IRB reviews both the informed consent document and the procedures for obtaining consent. Third, the criteria for subject selection is assessed to guard against exploitation of vulnerable subjects. Fourth, the IRB determines whether the potential risks to subjects are reasonable when compared to the anticipated benefits. Finally, the IRB reviews mechanisms for maintaining confidentiality of records. . . . The IRB cannot exist independent of the institution it monitors. The term "institutional review board" denotes the required institutional connection. Hence, institutional support is essential to the IRB's operations.

K. Tuthill, "Human Experimentation: Protecting Patient Autonomy Through Informed Consent," 18 J. Legal Med. 221, 232-33 (June 1997).

[8] "Informed consent" is defined in the Public Health Law as "the legally effective knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud deceit , duress or other form of constraint or coercion." PHL § 2441(5); 45 C.F.R. § 46.116; see also 14 N.Y.C.R.R. § 527.10(c)(4). Given the elements required for informed consent, it is impossible, as a practical matter, for a mental health professional to assess capacity to consent to participate in a research project without informing the patient of the nature of the study and the risks/benefits involved. See Pub. Health Law § 2441(5); 14 N.Y.C.R.R. § 527.10(e)(1)(ii); 45 C.F.R. § 46.116.

facility may nevertheless be capable of providing informed consent to medical treatment.[9]

The same determination of capacity employed in the health care context is used by mental health professionals to ascertain whether a patient may consent to participation in a research study, or whether the patient's surrogate should do so. (R. 9, 12-13) (Delano Aff.). This treatment-specific (or in the case of research, protocol-specific) definition of capacity means that a patient may be incapable of consenting to participate in one research project, but not another, and that such "capacity" may change over time. Even where a patient is deemed incapable, however, such patients retain the ability to object, which is respected in all cases. See R. 1518 (excluding patients incapable of objecting from participating in the study).

For this reason, the term "non-consensual" -- used throughout Plaintiffs' brief -- is a misnomer that wrongly equates forced participation in research[10] with research based on

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[9] See Rivers v. Katz, 67 N.Y.2d 485, 494 (1986) ("[M]any mentally ill persons retain the capacity to function in a competent manner . . . . [T]he nearly unanimous modern trend in the courts and among psychiatric and legal commentators is to recognize that there is no significant relationship between the need for hospitalization of mentally ill patients and their ability to make treatment decision"); (R. 2566) (Delano Aff.).

[10] Forced participation in research is prohibited by the invalidated OMH regulations on human subject research (14 N.Y.C.R.R. § 527.10(e)(2)(vi),(vii)); OMH regulations that govern medical treatment at OMH facilities (14 N.Y.C.R.R. § 527.8); N.Y. Pub. Health Law § 2441(5)(f); and the federal regulations, 45 C.F.R. § 46.116.

surrogate consent.[11] See, e.g., Pl. Br. at 33 (citing cases involving forced medication, over the patient's stated objection, with psychotropic drugs); Rivers v. Katz, 67 N.Y.2d 485, 491 (1986) (term "nonconsensual" refers to medication over objection). All research at OMH facilities is subject to the patient's informed consent, or the informed consent of a surrogate *and* the absence of any objection from the patient. Put another way, every study involves elements of consent (comprehension) and assent (voluntariness). Research may not continue under any circumstance once a patient orally or demonstrably indicates objection, even if that patient is deemed incapable of providing informed consent and even if the patient's surrogate consents. 14 N.Y.C.R.R. § 527.10(e)(2)(vi),(vii). Any medication over objection occurs only by court order issued pursuant to Rivers v. Katz, 67 N.Y.2d 485; see also 14 N.Y.C.R.R. § 527.10(e)(2)(viii).

Research studies are classified as involving either minimal risk or more-than-minimal-risk. "Minimal risk" refers to projects in which the "probability and magnitude of harm or

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[11] For the past several years, the Legislature has been debating the boundaries of surrogate consent for incapable patients. See A. 7026 (bill proposing to amend the Public Health Law to add Article 29-D, giving designated surrogates the authority to make treatment decisions for incapacitated patients, including termination of life-sustaining treatment, even in the absence of an advance directive, as long as certain conditions are met). See also A. 7166-B (1994), A. 6791 (1995), and A. 6791 (1996) (substantially the same bills as A. 7026).

discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests." 45 C.F.R. § 46.102(i). "More-than-minimal-risk" refers to any procedure, no matter how routine, that exceeds the harm or discomfort ordinarily encountered in daily life. Id. Accordingly, a venipuncture to draw blood, the administration of an FDA-approved drug that may carry side effects, and in fact, most standard medical procedures, are classified as "more-than-minimal-risk." (R. 2570) (Delano Aff.).

In the instant matter, Plaintiffs have consistently and misleadingly grouped these standard practices, together with other experimental practices, under the general rubric of "risky,"[12] a term that blurs the distinction between those risks which are attendant to FDA-approved drugs or procedures on the one hand, and those risks that arise because of the experimental nature of the study on the other hand. As the Appellate Division recognized, this Court "[i]n Rivers v. Katz . . . noted that numerous side effects are associated with the use of

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[12] Plaintiffs' casual use of the term "risky" is particularly egregious with respect to studies involving minors. Their brief states that children will be placed in "risky" experiments without their parents' knowledge or consent. (Pl. Br. at 15). Under Article 24-A and the federal regulations, this is clearly not the case, and even under the defunct OMH regulations, the provision was used in practice only for studies involving "no-more-than-minimal risk." 14 N.Y.C.R.R. § 527.10(e)(3)(iii); Delano dep., at 91-102 (Feb. 11, 1992).

antipsychotic and psychotropic drugs." (A. 4 n.1). Plaintiffs' brief, however, states that the Appellate Division "found that *experimentation risks*" (Pl. Br. at 10) included those risks which both the Appellate Division and this Court in Rivers had listed explicitly for antipsychotic and psychotropic drugs. See Rivers v. Katz, 67 N.Y.2d at 489 n.1. Thus, contrary to Plaintiffs' assertion (Pl. Br. at 10), Defendants have not concurred with Plaintiffs either as to the risks associated with the protocols at issue or the source of those risks. Id.

The Research Protocols

When the parties' motions for summary judgment were submitted to Supreme Court in 1992, there were over 400 human subject research studies underway at OMH-operated facilities. (A. 5). By this action, Plaintiffs have challenged only those studies that permit participation by incapable subjects and/or minors and involve more than minimal risk. Ten such studies existed in 1992 and became the subject of Plaintiffs' lawsuit: (1) Clozaril (Clozapine-Sandoz) in Treatment Resistant Patients (R. 466); (2) Desipramine Treatment of Depression in Alzheimer's Disease (R. 501); (3) Fibroblast Studies in Psychiatric Disorders (R. 715); (4) Schizophrenia Inpatient Research Unit Protocol (R. 683); (5) Neuropathology of Dementia in Elderly Schizophrenia Patients; (6) Prognostic Markers of Very Poor Outcome Schizophrenia (R. 1515); (7) Serotonin in Treatment Refractory

Schizophrenia (R. 1663); (8) Toward a Rational Use of Plasma HVA in Mental Illness (R. 1756); (9) Haloperidol Treatment in Alzheimer's Disease (R. 828); and (10) rCBF in Alzheimer's Disease (R. 1525). See (R. 2562) (Delano Aff.). Studies (1)-(4) are state funded, while studies (5)-(10) are federally funded. The Record is devoid of any indication of the factors used to determine whether a project receives federal or state funding.

(1) Clozaril in Treatment Resistant Patients

This study has led to the prescription of Clozaril, an FDA-approved drug[13] for treatment of refractory psychotic patients. See H. Meltzer, "Atypical Antipsychotic Drugs," in American Psychiatric Press Textbook of Psychopharmacology 1279 (A. Schatzberg & C. Meneroff, eds. 1995) ("Even some previously

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[13] "Clozaril (clozapine, Sandoz) . . . [is] marketed in over 20 countries. It has been used successfully in thousands of patients, many of whom had histories of being resistant to other neuroleptics. Clozaril has been the subject of numerous research reports which have attested to both its efficacy and safety, and because of its unique pharmacological profile has stimulated considerable interest in basic mechanisms of neuroleptic activity . . . . For patients receiving Clozaril, the attainment of therapeutic dosage levels is usually not impeded by the occurrence of dystonia or dyskinesia. In addition, novel structure may be the reason for its reported efficacy in other cases of stubborn psychotic symptomatology, where other treatment efforts have failed." (R. 479).

"As a result of the United States multicenter trial, the FDA approved the use of clozaril in 1990 for schizophrenic patients who are resistant to treatment with other antipsychotics or who are unable to tolerate conventional drugs because of . . . side effects or severe tardive dyskinesia. The clinician is left to decide how treatment resistance should be defined."
2 Comprehensive Textbook of Psychiatry VI 1979 (6th ed.) (H. Kaplan & B. Sadock eds. 1995).

regressed patients with marked defect symptoms have been able to return to work after clozaril"). In fact, following this study, New York Lawyers for the Public Interest (co-counsel for Plaintiffs as well as a Plaintiff) successfully brought an action to compel the State to place Clozapine on its Medicaid formulary. Alexander L. v. Cuomo, 154 Misc.2d 945 (Sup. Ct. New York Co. 1992).

The study was not approved for minors (R. 470), and involved the prescription of Clozapine for a specific subset of patients in OMH facilities. The 14-day "washout period" is standard clinical practice before initiating any Clozapine use, not merely in the research context.[14] Specifically, the risks of leukopenia, agranulocytosis, hypotension, tachycardia, and hypersalivation arise from the standard use of Clozapine[15] and not from its application in this patient subset. (R. 471, 479). Plaintiffs ignore this distinction.

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[14] "Initiation of clozapine treatment should ordinarily be done in patients free of other psychotropic drugs to minimize side effects . . . and to avoid interference with those benefits of clozapine that are dependent on weak [dopamine] receptor blockade." H. Meltzer, "Atypical Antipsychotic Drugs," in American Psychiatric Press Textbook of Psychopharmacology 1279 (A. Schatzberg & C. Meneroff, eds. 1995). Typical antipsychotics, such as Haloperidol, act as dopamine receptor blockades. See infra at 22.

[15] "There have been no definite reported cases of tardive dyskinesia linked to clozapine treatment alone. At the same time, clozapine appears effective in blocking this syndrome in up to 67% of patients." H. Meltzer, "Atypical Antipsychotic Drugs," supra, at 1280.

Moreover, because of the risk of agranulocytosis, patients in this study -- just like all Clozapine patients -- are subject to weekly monitoring blood tests[16] so that Clozapine can be stopped where necessary. (R. 471). We thus note that this entire study, including venipuncture, would be therapeutic even under Plaintiffs' rigid definitions. See generally Pl. Br. at 11, 23, 46 n.2; (R. 2909).

(2) Desipramine Treatment of Depression in Alzheimer's Disease

This protocol involves no experimental treatment (R. 507), and as the title makes clear, does not contemplate participation by minors. Moreover, the protocol requires two consents, one from the patient and another from a family member. (R. 507) ("In addition to patient consent, a family member will also be required to provide informed consent"). See also R. 508 (Desipramine was selected for this study precisely because of its mild side effects, such as dry mouth).

In order to monitor cerebral blood flow as an indicator of the efficacy of Desipramine use on the subject, rCBF (regional cerebral blood flow) tests were required. (R. 508). rCBFs involve the inhalation of Xenon 133, an inert isotope

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[16] See also H. Meltzer, "Atypical Antipsychotic Drugs," supra, at 1280; 2 Comprehensive Textbook of Psychiatry VI 1984 (6th ed.) (H. Kaplan & B. Sadock eds. 1995); Alexander L., 154 Misc.2d at 946 ("the FDA's approval of Clozapine is linked to a distribution scheme which requires safety monitoring through a program which includes weekly blood testing with the dispensation of the drug.").

administered at levels well below those considered safe by federal regulators. (R. 1532-33); see also G. Greisan, "Cerebral Blood Flow in Infants and Children," in Handbook of Regional Cerebral Flow 244 (Knezevie, Maximilian, Mubrin & Proohovnik, eds. 1988) (the whole body exposure to radiation in rCBF is roughly equivalent to a round trip flight from New York to Los Angeles, and has been reported to be less than a single chest x-ray). Finally, this study also involves venipunctures for monitoring purposes. (R. 508). We note that, according to Plaintiffs' definition both the rCBF and the venipuncture are non-therapeutic, and consequently, would render this research study non-therapeutic. (R. 2909).

(3) Fibroblast Studies in Psychiatric Disorders

A "fibroblast" is a type of skin cell that is used to create a tissue culture on which tests can be performed,[17] and is a standard part of clinical testing. (R. 725). The purpose of this 1987 study was to attempt to identify potentially-treatable enzyme deficiencies in patients with schizophrenia. (R. 722, 724). Accordingly, cell samples from schizophrenic patients were necessary. The protocol applies only to persons between 18 and 45 years old (R. 729), and is subject to specific informed consent protections. (R. 730).

In order to obtain a fibroblast, researchers must perform a

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[17] Stedman's Medical Dictionary 581 (Williams & Wilkins 1990) (25th ed.).

skin punch biopsy, a medically approved procedure that involves application of a topical anesthetic followed by the removal of a 3-millimeter wide and 2-millimeter deep patch of skin. (R. 725, 730). While there is no immediate benefit to the patient from providing the skin cell sample, the study could result in the identification of those schizophrenic study subjects who suffer from enzyme deficiencies, and for whom drugs may already be available to treat the deficiency.

We note that Plaintiffs' brief includes skin punch biopsies in a parade of horribles among those experimental procedures that create the risk of death, tardive dyskinesia,[18] or other permanent physical impairments. See Pl. Br. at 10 ("skin biopsies".are "highly invasive painful testing procedures"). Skin punch biopsies, however, are treated with application of a

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[18] Tardive dyskinesia is

> a movement disorder that may occur following chronic treatment with antipsychotic medications. . . . At least 10%-20% of patients treated with neuroleptics for more than one year develop [tardive dyskinesia]. In chronically institutionalized patients, the prevalence is 15%- 20%. . . . [Tardive dyskinesia] does not appear to be a progressive disorder for most patients. It seems to develop rapidly and to then stabilize and often to improve. A number of studies have followed the course of [tardive dyskinesia] in patients who were continued on drugs for several years. . . . [I]mprovement can be clinically meaningful in some patients.

S. Marder & T. Van Putten, "Antipsychotic Medications," in American Psychiatric Press Textbook of Psychopharmacology 256-57 (A. Schatzberg & C. Meneroff, eds. 1995) (emphasis added).

bandaid and are monitored for a few days for infection. (R. 730); see also R. 719, 733 (in application for extension of protocol, researchers stated that there had been no adverse reactions in the study to date).

(4) *Schizophrenia Inpatient Research Unit Protocol: Family and Treatment Study (New York State Psychiatric Institute)*

The purpose of this study was to identify symptoms or patterns of behavior that distinguish sporadic schizophrenia (i.e., isolated occurrences) from schizophrenia that appears to be genetically-based, given the incidence of the disease in the patient's family members. The study involves a "washout" period only to distinguish the patient's actual symptoms from the side-effects (if any) of psychotropic medication. (R. 685). Thereafter, patients receive one of two types of FDA-approved medications to determine whether either is more effective for the type of schizophrenia (i.e., sporadic or genetic) that the patient exhibits. This protocol, which was approved only for adults, involves no experimental drugs or the experimental use of approved drugs. (R. 698); see also R. 691 ("[a]s with all subjects, if the person declines to participate after the nature of the study has been explained, their decision will be respected").

(5) *Neuropathology of Dementia In Elderly Schizophrenia Patients: Pilgrim Psychiatric Center*

There is no information in the Record with respect to this

protocol.

(6) *Prognostic Markers of Very Poor Outcome Schizophrenia*

The purpose of this study is to identify biological or symptomatic features that predict poor-outcome schizophrenia.[19] (R. 1523). "The Prognostic Marker Study is consisted of only non-invasive elements." (R. 1523). Both Haloperidol and Cogentin are FDA-approved and involve the same risks in this study as they do when administered in the clinical treatment setting. The protocol for this study explicitly provides that a patient cannot participate in the research if (s)he lacks the capacity to object and/or the family or guardian objects. (R. 1518). As an added protection, family members of capable patients will be notified of the patient's consent to participate in the study. (R. 1517).

(7) *Serotonin in Treatment Refractory Schizophrenia*

This study sought to establish a method of predicting which previously treatment-resistant patients (between 18 and 60 years old (R. 1683)) would respond to Clozapine, an FDA-approved, "atypical" neuroleptic drug. (R. 1664).[20] Because many

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[19] This type of schizophrenia is known as "Kraepelinian" and patients are thus classified if there is evidence of at least 5 years of an inability to provide themselves with food, clothing, shelter, and 5 years without employment and without remission. (R. 1519).

[20] "Patients will be informed of the risks involved with neuroleptic treatment and in particular the potential complications attributed to clozapine." (R. 1680).

schizophrenics have increased production of dopamine in their systems (id.), the research first involved administration of Haloperidol (FDA-approved, "typical" neuroleptic drug) to identify which patients in the study would respond to the dopamine blockers,[21] the basic function of Haloperidol and other conventional schizophrenia medications. (Id.) About 20% of treatment-resistant schizophrenics, however, have no dopamine dysfunction, meaning that Haloperidol and other similar drugs would have no effect in their treatment. (Id.). Clozapine, unlike other schizophrenia drugs, does not work on dopamine production, but rather, contains "serotonin antagonists." If Clozapine is effective in those schizophrenic patients who do not respond to Haloperidol, then: (1) through the research study they can receive medical treatment to relieve their schizophrenic symptoms; and (2) the results of the study help establish that some schizophrenics with high serotonin levels may benefit from immediate treatment with Clozapine rather than the conventional Haloperidol treatment, thus reducing delay towards recovery and

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[21] This study involved two "washout" periods. The first, preceding entry into the study, was intended to permit researchers to identify with accuracy whether patients were responding to the treatment rather than to residual traces of other drugs in the bloodstream. Any patient who suffered aggravated schizophrenic symptoms during this phase was withdrawn from the study and treated with medication. (R. 1680). The second washout followed the administration of Haloperidol; however, given that only those patients who did not respond to Haloperidol moved on to the Clozapine phase of the research, the risk of aggravated symptoms is small. (R. 1680).

maintenance. (R.1664).

We note that serotonin is measured in spinal fluid, and thus, this study involves lumbar punctures, a well-known and widely used procedure that entails the risk of bad headache in about 10% of patients. See R. Fishman, Cerebrospinal Fluid Disease of the Nervous System (2d ed. 1992). Because a lumbar puncture is non-therapeutic, its use in this protocol -- notwithstanding its utility -- renders the study non-therapeutic under Plaintiffs' definition.

(8) Toward a Rational Use of Plasma HVA in Mental Illness

Plasma HVA is a by-product of dopamine. (R. 1757). As discussed supra, many schizophrenic patients suffer from abnormal dopamine levels, which would be reflected in similarly abnormal Plasma HVA levels. However, while it is difficult to take accurate measurements of blood-dopamine levels, it is possible to measure Plasma HVA with accuracy. (R. 1757). Like Protocol (7), this study attempts to identify a valid predictive test to reduce delay in providing care to schizophrenic patients. See R. 1781-84 (citing numerous scientific studies from 1970s and 1980s linking dopamine and Plasma HVA levels with schizophrenic behavior). By accurately measuring Plasma HVA, and consequently, dopamine levels, mental health care professionals would be able to prescribe the appropriate drug at the outset of clinical treatment. (R. 1757).

We note that Clozapine could be prescribed outside of the research study, and without measurement of Plasma HVA levels. Accordingly, this portion of the protocol, together with administration of rCBF tests, supra, would be classified as "non-therapeutic" by Plaintiffs,[22] thus rendering the entire protocol non-therapeutic. (R. 2909). When Clozapine was first approved, however, most health care professionals were reluctant to initiate treatment with Clozapine, given its recognized side-effects. See H. Meltzer, "Atypical Antipsychotic Drugs," in American Psychiatric Press Textbook of Psychopharmacology, supra, at 1278 ("Because of its ability to cause granulocytopenia or agranulocytosis in 1% to 2% of patients, clozapine has usually not been considered to be a first line drug for the initial treatment of schizophrenia or for those chronic patients whose positive symptoms respond to typical antipsychotic drugs."). This study attempted to help identify chemical markers that assist in those treatment decisions.

(9) Haloperidol Treatment in Alzheimer's Disease

Haloperidol is, as noted above, an FDA-approved drug that may be prescribed over a wide range of doses. (R. 830). The purpose of this 1987 study was to identify the optimal dose of Haloperidol in an Alzheimer's population, where a typically high dosage of the drug often results in measurable side effects. (R.

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[22] National Bioethics Advisory Commission, supra n. 8, at 236-37 (Testimony of Ruth Lowenkron).

830). In fact, tardive dyskinesia, a risk in every Haloperidol administration, is lessened at the low dosages of this research trial. (R. 837) ("The risk of tardive dyskinesia is low given the low doses and short study duration"). The protocol explicitly indicates that this research study does not involve either experimental drugs or an experimental use of an approved drug. (R. 836).

We note that a "non-therapeutic" aspect of this study is the administration of an rCBF test, see supra, which involves the inhalation of the inert isotope Xenon 133, at levels which are below the acceptable levels under federal regulation. (R. 1532-33); see also G. Greisan, "Cerebral Blood Flow in Infants and Children, in Handbook of Regional Cerebral Flow 244 (Knezevie, Maximilian, Mubrin & Proohovnik, eds. 1988) (the whole body exposure to radiation in a rCBF is roughly equivalent to a round trip flight from New York to Los Angeles, and has been reported to be less than a single chest x-ray). Accordingly, this research study -- which involved no more risk than that involved in the clinical prescription of Haloperidol, and which ultimately resulted in the identification of the optimal Haloperidol dosage for these patients and other Alzheimer's victims -- is classified by Plaintiffs as "non-therapeutic" because of the rCBF monitoring involved.

(10) rCBF in Alzheimer's Disease

The purpose of this research study is to complete the documentation of use of the rCBF test as a diagnostic marker of Alzheimer's Disease. (R. 1527). It involves no medication, no experimental biological products, and no experimental use of approved drugs. (R. 1529, 1531). Rather, it entails ongoing cognitive and physical tests, accompanied by the administration of periodic rCBF tests. (R. 1528-29). As noted at several points above, the rCBF test involves exposure to an inert isotope at levels below those considered safe by federal regulators. (R. 1533); see also supra.

The rCBF is an effective diagnostic marker of the condition. Moreover, patients who suffer from other treatable conditions that "mimic" Alzheimer's symptoms (e.g., depression, dementia, and hydrocephalus) could receive appropriate treatment. (R. 1533). We note that Plaintiffs nevertheless classify this study as non-therapeutic, because it involves only diagnosis (even if that diagnosis can lead to treatment for a subset of patients) and the use of an inert isotope at federally approved levels.

THE MATTER AT BAR

Plaintiffs commenced this action against Defendants by summons and complaint dated February 21, 1991. The complaint alleged, in sum, that OMH regulations governing human subject research were unlawful because (1) they exceed the statutory grant of authority to OMH; and alternatively, (2) they fail adequately to protect the constitutional, statutory, and common

law rights of patients in OMH facilities who participate in human research studies.

On September 3, 1992, Plaintiffs, having taken extensive discovery, moved for summary judgment; on November 13, 1992, Defendants cross-moved for summary judgment. By decision dated February 28, 1995 (R. 21), and order and judgment entered June 26, 1995 (R. 12), Supreme Court, New York County (Greenfield, J.), granted Plaintiffs' motion for summary judgment and invalidated the challenged OMH regulations. Noting that Plaintiffs' action is not a "broad-based challenge" against all human subject research, but addressed those procedures, if any, that create a risk of death or serious disability "and which . . . offer no direct therapeutic benefit to the participating subjects" (R. 24-25), the court determined that: (1) OMH lacked statutory authority to promulgate the regulations at issue; (2) PHL Art. 24-A governs the conduct of human subject research, and the Commissioner of Health has not given consent to experiments on incapable adults and minors; and (3) it was unnecessary to reach constitutional issues because the case was decided on statutory interpretation grounds. (R. 41).

On June 27, 1995, Defendants noticed an appeal to the Appellate Division, First Department (R. 3).[23] On July 13, 1995,

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[23] By order entered August 3, 1997, the Appellate Division vacated Defendants' stay under CPLR 5519(a)(1). (R. 2900). Ongoing federally-funded research projects, however, continued until August 21, 1995, when Plaintiffs obtained a Temporary

Plaintiffs cross-appealed.

By decision and order dated December 5, 1996, the Appellate Division affirmed Supreme Court's judgment and order and invalidated the OMH regulations, reasoning that OMH lacked the authority to issue them. (A. 1). Like Supreme Court, the Appellate Division concluded that "OMH lacked the authority to promulgate the challenged regulations governing human subject research as such authority is given exclusively to the Commissioner of the Department of Health pursuant to Article 24-A of the Public Health Law." (A.5). It further concluded that, pursuant to PHL § 2444(2), non-federally funded, more-than-minimal-risk therapeutic research on incapable subjects and non-federally funded more-than-minimal-risk therapeutic research on minors could not proceed absent consent from the Commissioner of Health. (A. 10).

Restraining Order prohibiting the completion of ongoing, "non-therapeutic" more-than-minimal risk research studies based on surrogate consent. (R. 2901).

In January 1996 Plaintiffs obtained a second Temporary Restraining Order directing the immediate cessation of all research studies involving "non-therapeutic" and "possibly therapeutic" experiments based on surrogate consent. The Order permitted therapeutic research to continue for incapable patients if prior court approval could be obtained. (R. 2904).

In February 1996, and again in March 1996, the parties entered into Stipulations precisely to clarify the definitions of ambiguous key terms that were the source of confusion in implementing Justice Greenfield's decision. Specifically, "therapeutic" and "non-therapeutic" research required definition. (R. 2909, 2913).

Notwithstanding that the OMH regulations would no longer be effective as a consequence of the affirmance, and notwithstanding that Article 24-A prohibits continued research on incapable adults and minors absent the Commissioner's approval, the Appellate Division next applied a constitutional analysis to the defunct OMH regulatory scheme: the "*challenged regulations* do not adequately safeguard and therefore violate the State and Federal constitutional rights to due process . . ." (A. 5) (emphasis added).[24]

Predicating its analysis on the unstated assumption that surrogate consent to human subject research is tantamount to

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[24] "Accordingly, the order and judgment (one paper) of Supreme Court, New York County (Edward J. Greenfield, J.), entered on about June 26, 1995, which denied defendants' cross-motion for summary judgment and granted plaintiff's motion for summary judgment and ordered, adjudged and declared, inter alia, that the regulations codified at 14 N.Y.C.R.R. § 527.10 were promulgated by the Commission of the [OMH] beyond his authority and without the consent of the Commissioner of Health are thus invalid and unenforceable in their entirety and for all purposes, should be modified, on the law, to also order, adjudge and declare that the following provisions of the regulations promulgated by the [OMH] and codified at [14 N.Y.C.R.R. §§ 527.10, 527.10 (e)(2)(ii) and (e)(2)(ix); 527.10(e)(2)(viii); 527.10(e)(2)(iii) and (iv); and 527.10(e)(3)(i)], fail to provide for adequate notice and review procedures and therefore violate the due process clause of the New York State Constitution (Article I, § 6) and the due process clause of the Fourteenth Amendment of the United States Constitution, and violate this State's common law as well as Public Health Law Article 24-A and Social Services Law Article 6, Title I, and otherwise affirmed, without costs."

A. 52 (emphasis added).

surrogate consent for withdrawal of life-sustaining treatment,[25] the Appellate Division again found the OMH regulations invalid because (1) as to therapeutic research, they provided no judicial review of capacity determinations (14 N.Y.C.R.R. § 527.10(e)(2)(ix)), and (2) as to non-therapeutic research, they did not require either an advance directive, or clear and convincing evidence, by the patient to express his/her wish to participate in human subject research. 14 N.Y.C.R.R. § 527.10(e)(2)(iii)-(iv); (A. 38-39, 42). See also 14 N.Y.C.R.R. § 527.10(e)(2)(ii) (provision authorizing IRBs to review consent procedures invalidated because it fails to provide for conflicts of interest).

The Appellate Division also considered whether parental consent to research involving minors, therapeutic or otherwise, is constitutionally permissible under the invalidated OMH regulations. The court concluded that neither the federal nor the State Constitution forbids parents from consenting to therapeutic research on behalf of their minor children, in essence treating therapeutic research in the same manner as standardized medical treatment. (A. 47). However, the Appellate Division prohibited all non-therapeutic, more-than-minimal risk research on minors based on parental consent under the OMH regulations (14 N.Y.C.R.R. § 527.10(e)(3)(i)) (A. 47), and

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[25] As we shall demonstrate below (infra at 43-48), this assumption is incorrect.

declined to examine whether the federal regulations would permit non-therapeutic, more-than-minimal risk research performed on minors with parental consent. (Id.).

The Appellate Division then turned to the constitutionality of a provision in the OMH regulations permitting the IRB to waive the parental consent requirement for certain research studies involving consenting minors (14 N.Y.C.R.R. § 527.10(e)(3)(iii)). (A. 46-47). The court concluded that any such research requires a judicial finding of abuse and neglect under the Family Court Act and the Social Services Law. See N.Y. Family Court Act Art. 6; N.Y. Soc. Servs. Law § 383-b. (Id.).

Finally, the Appellate Division found unconstitutional (A. 50-51) those provisions of the invalidated OMH regulations that permitted the override of an incapable adult's objection to therapeutic research. 14 N.Y.C.R.R. § 527.10(e)(2)(viii). In articulating its constitutional concerns, the Appellate Division explicitly excluded all federally-funded research and non-federally funded research that is subject to PHL Art. 24-A from its reach. Although the court did not provide a constitutional basis for so doing, it is clear that the constitutional analysis -- intended solely as a guide for future DOH regulations -- had no relevance for existing federal regulations or State law. (A. 5).

The parties thereafter separately moved for clarification of the Appellate Division's decision, but those motions were denied.

(A. 59). Defendants also moved in the Appellate Division for leave to appeal to this Court, which the Appellate Division also denied. (Id.).

On January 8, 1997, Plaintiffs noticed an appeal to this court as of right, which was dismissed on April 1, 1997. On May 9, 1997, Plaintiffs then moved for leave to appeal, which this Court granted by order dated July 1, 1997.

ARGUMENT

POINT I

THE APPELLATE DIVISION'S CONSTITUTIONAL ANALYSIS IS AN ADVISORY OPINION

The Appellate Division, employing a statutory analysis not presently contested either by Plaintiffs or Defendants, concluded that OMH lacked the authority to promulgate regulations governing human subject research, and annulled those regulations in their entirety. Thus, the court's subsequent constitutional analysis of those invalidated regulations, unnecessary to resolve an actual dispute before it, contravenes well-established rules of decision. Moreover, the Appellate Division's assertion that its constitutional analysis of the invalidated regulations was necessary because of the anticipated future actions of Defendants renders that portion of the decision an advisory opinion, or at least mere dictum. Consequently, Plaintiffs' effort on appeal to expand the scope of that opinion -- either to federally-funded research or to non-federally funded research to be conducted

under DOH regulations that have not yet been written -- is an improper attempt to derive an advisory opinion from this Court on an abstract question.

A. Because the Invalidation of OMH Regulations Was Based on Statutory Interpretation, and the Appellate Division Had No Need to Conduct its Constitutional Analysis, This Court Should Decline to Expand the Scope of That Constitutional Inquiry

It is well-established that a constitutional analysis should not issue if the case can be resolved on other grounds. Syquia v. Board of Ed., 80 N.Y.2d 534, 535 (1992) ("Under established principles of judicial restraint . . . courts should not address constitutional issues when a decision can be reached on other grounds") (citing Matter of Beach v. Shanley, 62 N.Y.2d 241 (1984)). To the extent that the Appellate Division disregarded this principle of judicial restraint expressly to shape -- at the outset and in an advisory capacity -- regulations that the Commissioner of Health may promulgate in the future, this Court should not compound that error by addressing Plaintiffs' constitutional arguments on this appeal.

The Appellate Division's decision first invalidated on statutory grounds the OMH regulations governing human subject research. (A. 52). Neither Plaintiffs nor Defendants have appealed the court's determination that authority over human subject research appropriately vests with the Department of Health. (R. 95) (Complaint ¶ 1) ("This suit challenges the

legality of regulations of the New York State Office of Mental Health ("OMH") which would permit patients in psychiatric hospitals in New York State to be used as human guinea pigs in experimental research without their consent"). The court's subsequent constitutional analysis, regardless of motivation, solely addresses those same regulations that it already had invalidated. See, e.g., A. 5 (the "*challenged regulations* do not adequately safeguard and therefore violate the State and Federal constitutional rights to due process") (emphasis added); A. 52 (striking various provisions of the already-invalidated OMH regulations as violative of state and federal constitutions). As such, this portion of the decision violates a basic rule of decision by attempting to create constitutional law in the absence of any real need to do so. This Court should decline to extend it as requested by Plaintiffs.

B. The Appellate Division's Constitutional Analysis Is An Advisory Opinion and As Such, This Court Should Not Address Its Purported Deficiencies

The doctrine of justiciability (subsuming advisory opinions, ripeness issues, and political questions) identifies appropriate occasions for the exercise of judicial authority and "represents perhaps the most significant and least comprehended limitation upon the judicial power." New York State Inspection, Security, & Law Enforcement Employees v. Cuomo, 64 N.Y.2d 233, 238 (1984).

Only matters that are consistent with the judicial function, and which are properly presented before the court, are deemed justiciable. Id. New York courts steadfastly observe the rule against advisory opinions, as such opinions have no immediate effect and may never actually resolve anything. Cuomo v. Long Island Lighting Co., 71 N.Y.2d at 354 (quoting NYPIRG v. Carey, 42 N.Y.2d 527, 531 (1977)). This rule is not merely one of prudence, but rather, is a "constitutional command" defining the role of the courts in a common law system. NYPIRG v. Carey, 42 N.Y.2d 527, 529 (1977).

It is settled law that an opinion would be advisory if the question presented involves a future event which may not occur. Id. at 354 (where claimed harm is "contingent upon the enactment of legislation in the future, the dispute [is] not justiciable") (citing Matter of State Indus. Comm'n, 224 N.Y. 13 (1918) (Cardozo, J.)). Thus, for example, a constitutional analysis of regulations that have not yet been implemented must be rejected. See Herzog Bros. Trucking, Inc. v. State Tax Comm'n, 72 N.Y.2d 720, 725 (1988) (constitutional analysis of future potential application of regulations, which may not occur, is an advisory opinion).

The portion of the Appellate Division's decision analyzing the constitutionality of invalidated regulations is plainly an advisory opinion. The court included its analysis of the defunct regulations in an attempt to advise Defendants of the legality of

their anticipated future conduct. (A. 28, 34). The Record, however, is devoid of any indication from the Department of Health about its plans in this field, and the statutory schemes in Article 24-A and under the federal regulations are notably different from the invalidated OMH regulations. A judicial advisory opinion directed at the issuance of future regulations is particularly inappropriate where, as here, it is issued under a mistaken impression of the environment in which the regulations would issue. Moreover, in light of the broad protections for human subject research under federal law and the legislative intent reflected in PHL § 2445, the Commissioner might well decline to issue further regulations applicable to federally funded research. Accordingly, the Appellate Division's entire constitutional analysis is a hypothetical exercise that should not be extended beyond its own stated reach.

The extension of this advisory opinion to all federally-funded research is particularly troublesome. First, the Record is devoid of any evidence about the federal aspect (if any) of those projects, and in fact, the legality of those regulations was not contested by these Plaintiffs. (R. 95). Having challenged only the propriety of OMH regulations, Plaintiffs may not now seek to effectively nullify the federal regulations and/or PHL Art. 24-A by advocating the extension of dicta contained in the Appellate Division's decision. See, e.g., Snyder v. Wetzler, 84 N.Y.2d 941, 942 (1994) (Court declined to

consider constitutional and state law claims not contained in the complaint); Matter of Schulz v. State, 81 N.Y.2d 336, 344 (1993) (Court declined to consider standing theory not alleged in pleadings); People v. Two Wheel Corp., 71 N.Y.2d 693, 697 (1988) (vagueness challenge not raised in answer unpreserved); Quain v. Buzzetta Contr. Corp., 69 N.Y.2d 376, 380 (1987) (legal theory not raised in pleadings or trial court motions not properly before Court).

In addition, Plaintiffs cite no portion of the Record demonstrating how federal vs. state funding decisions are made; the nature of the research conducted with federal funds; instances of abuse (if any) of a patient's rights in federally-funded studies; and the efficacy of the federal regulations in the day-to-day setting at OMH facilities and other facilities in New York and elsewhere. See Genesis of Mt. Vernon v. Zoning Bd., 81 N.Y.2d 741, 745 (1992) ("we have found it particularly important . . . to adhere to our admonition that 'the constitutionality of statutes ought not be decided except in an actual factual setting that makes such a decision necessary'") (citing Pennell v. San Jose, 485 U.S. 1, 10 (1988)) (quoting Hodel v. Virginia Surface Mining & Reclamation Ass'n, 452 U.S. 264, 294-95 (1981))). In the absence of such information, the extension of the Appellate Division's speculative analysis would be imprudent and would interfere with important research directly benefitting the patient population that Plaintiffs are entrusted

to protect.

In sum, the Appellate Division's constitutional analysis is speculative, premised on uninformed assumptions about the motivations of the Commissioner of the Department of Health, and constitutes an inappropriate exercise of judicial authority. See New York State Inspection, Security, & Law Enforcement Employees v. Cuomo, 64 N.Y.2d at 240 ("Where the harm sought to be enjoined is contingent upon events which may not come to pass, the claim to enjoin the purported hazard is nonjusticiable as wholly speculative and abstract") (citing NYPIRG v. Carey, 42 N.Y.2d 527 (1977)). As such, this advisory opinion should not be extended, as Plaintiffs request, to hinder research conducted pursuant to appropriately-promulgated regulations.

C. This Case Does Not Fit Within the Established Exceptions for Constitutional Analyses Pegged to Future Occurrences

The Appellate Division implicitly recognized the advisory nature of its constitutional analysis by relying on NYPIRG v. Carey, supra, to justify that portion of its decision. (A. 28). The Appellate Division, however, failed to consider whether the factors identified by the NYPIRG court to justify a constitutional analysis pegged to a future event are present in this case. In fact, none of the NYPIRG factors exist here.

NYPIRG involved a constitutional attack on a legislative enactment that required a proposition to be placed on the ballot authorizing a state debt of $750 million for unspecified capital

improvement projects. The necessary parties had already drafted the proposition when this lawsuit was brought, but without voter approval the statute had no legal effect. NYPIRG discontinued its challenge to the proposition, but pressed its challenge of the proposed statute in light of the constitutional mandate (Art. VII, § 11) that debts incurred by the state must be for a "single work or purpose."

This Court considered whether it could validly address the constitutionality of the statute, given that the unitemized debt would exist, if ever, only upon future voter approval of the ballot proposition. It first noted that, generally, courts should not rule on the constitutionality of a statute or ordinance until it has passed. NYPIRG, 42 N.Y.2d at 531.

> That is not to say that the courts may never consider the validity of proposed legislation. This has been done on several occasions, although with reluctance and then only incidentally to resolve a dispute as to whether the proposition should be placed or remain on the ballot.

Id. (emphasis added); see also Fossella v. Dinkins, 66 N.Y.2d 162, 167 (1985) (per curiam) (even where the NYPIRG exception applies, the Court will first rely on statutory grounds to resolve a case). In those circumstances, the outcome of the election -- while a future event -- is irrelevant, because the proposition itself may be fatally defective, and thus, a waste of "the expense and human effort involved in the election process." Id. at 532. However, as the plaintiffs in NYPIRG sought the

constitutional review of the unapproved statute, rather than the proposition, this Court declined to provide such a contingent opinion. Id.

Subsequently, in Cuomo v. Long Island Lighting Co., supra, this Court observed that the exception articulated in NYPIRG is a "strike from the ballot" exception, and that every case cited in NYPIRG involved a request to strike a proposition from an electoral ballot. 71 N.Y.2d at 355. In addition, this Court recognized that in the case of ballot propositions, the court "could be satisfied that it was assessing the final form of the document." Id. at 356.

None of the predicates for the NYPIRG exception is present here. This case obviously does not involve a ballot proposition or any other aspect of the electoral process. In addition, this Court cannot be satisfied that it is assessing the final form of the regulations that ultimately will govern human subject research in New York, as no such regulations have even been drafted. Consequently, in the absence of any judicially-recognized exception to the mandate against advisory opinions, this Court must reject the Appellate Division's constitutional analysis and decline to extend it as requested by the Plaintiffs.

POINT II

BECAUSE THE APPELLATE DIVISION'S CONSTITUTIONAL ANALYSIS WAS BASED UPON ERRONEOUS PRESUMPTIONS, IT SHOULD NOT BE EXTENDED TO ALL HUMAN SUBJECT RESEARCH ON MENTALLY ILL PERSONS

This case presents moral, ethical, social and legal issues about the progress of human subject research that should not be resolved in the absence of a fully-developed record or without a full understanding of the ethical principles that guide the research community.[26] The Record here is devoid of the necessary information, primarily because Plaintiffs' Complaint did not attack the constitutionality of research conducted in accordance with Article 24-A or the federal regulations.

A. The Appellate Division Failed to Address the Threshold Question of the Nature of Human Subject Research Under the Law

The Appellate Division concluded, without any analysis, that a decision to participate in a human subject research study is analytically the same as a decision to withdraw life-sustaining treatment. Each of this Court's decisions on surrogate consent to terminate life-sustaining treatment, however, has identified the operative factors as (1) the power of the surrogate over the life and death (2) of another person unable to articulate his/her

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[26] The ethical guide for human subject research in the United States has been the Helsinki Declaration of 1989, which provides that a legal guardian may consent for a subject who is legally incompetent. See R. Field, "Children as Research Subjects: Science, Ethics & Law," Book Review, 16 J. Legal Med. 311, 315 (June 1995). In addition, the American Bar Association has taken the position that non-therapeutic experimentation on institutionalized mentally disabled persons is ethically permissible under specific circumstances (which are consistent with the federal regulations). See M. Loscialpo, "Nontherapeutic Human Research Experiments on Institutionalized Mentally Retarded Children: Civil Rights and Remedies," 23 New Eng. J. on Crim. & Civ. Confinement 139 (Winter 1997).

own desires in this regard. The Appellate Division ignored both aspects of this rule.

1. OMH patients are not necessarily incapable of objecting to participation in research studies.

As this Court made clear in Rivers v. Katz, a patient in an OMH facility, even if incapable of providing informed consent, nevertheless ordinarily retains the ability to object effectively. Rivers, 67 N.Y.2d at 497-98 (objection of incapable OMH patient will be honored absent clear and convincing showing by State that narrowly tailored treatment plan is in patient's best interest); R. 1518 (excluding patients incapable of objecting from being considered for the study); National Bioethics Advisory Commission, supra n. 10, at 212 ("Yes, if the individual objected they [OMH] would not do it and, of course, we think that is an important safeguard") (Testimony of Ruth Lowenkron).

Under the invalidated OMH regulations, every patient can orally or demonstrably override the consent of a surrogate, even if that patient is otherwise deemed incapable of providing informed consent. 14 N.Y.C.R.R. § 527.10(e)(2)(vi), (vii). The Appellate Division's analysis implicitly assumes, however, that mentally ill persons are always incapable of objecting to unwanted intrusions to bodily integrity. (A. 34). That assumption is inconsistent with this Court's decision in Rivers v. Katz, supra, and strips OMH patients of the ability to

exercise control over their own bodies by deciding to assent or object to any bodily intrusion. See, e.g., 14 N.Y.C.R.R. § 527.8(c); see also Brief of American College of Neuropsychopharmacology, et al. *amici curiae*, at 18.

2. Rules governing surrogate decisions over life-and-death do not apply to human subject research.

Under this Court's precedent, the common-law right to terminate or refuse life-sustaining treatment -- that is, to exercise the power of life and death -- is personal to the patient, and cannot be exercised by a surrogate on behalf of an incapacitated patient absent an advance directive, or clear and convincing evidence that the patient would not have wanted such treatment. See, e.g., Fosmire v. Nicoleau, 75 N.Y.2d 218, 226 (1990) ("[t]he common law of this State established the right of a competent adult to determine the course of his or her own medical treatment"); Matter of Storar, 52 N.Y.2d 363, 376-77 (1981) (same); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30 (1914) (same); see also Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269-70 (1990) (citing Storar and Schloendorff, concluded that medical decisions which result in patient's death are personal to the patient); id. at 279 n.7 ("[a]lthough many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held").

In Storar, this Court recognized that in the context of

life-and-death decisions "to permit a third party to choose between the two means, in effect, that the right to life is lost once the patient becomes incompetent." Matter of Storar, 52 N.Y.2d at 378; see also Matter of Westchester Co. Med. Ctr., 72 N.Y.2d 517, 530-31 (1988) ("[e]very person has a right to life, and no one should be denied essential medical care unless the evidence clearly and convincingly shows that the patient intended to decline the treatment"); id. at 534 n.5 ("no one should be denied life-sustaining treatment when there is not clear and convincing evidence that this was in fact the patient's choice"). The operative factor limiting surrogate consent power in such cases is that the surrogate's decision would deprive the incapacitated patient of life. Grace Plaza of Great Neck v. Elbaum, 82 N.Y.2d 15, 16-17 (1993).

In the instant case, the research protocols challenged by Plaintiffs simply do not present patients, their families, or their doctors with life-and-death decisions,[27] because the risks

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[27] Even if those common law rules do apply, this Court has recognized on various occasions that the State Legislature could permit certain types of decision-making by statute. See, e.g., Matter of Westchester Co. Med. Ctr., 72 N.Y.2d 517, 528 n.2 (1988) (New York's law prohibiting surrogate consent to terminate life-sustaining treatment "has been changed to some extent by legislation"); Storar, 52 N.Y.2d at 382-83 (modifications to rule enunciated by this Court could come only from Legislature); and see Matter of Leonard C., 164 Misc.2d 518, 524 (Sup. Ct. Albany Co.) ("absent a constitutional legislative enactment, living wills cannot be imputed to those who are incompetent to make them), modified on other grounds, 221 A.D.2d 896 (3rd Dept. 1995); Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269 (1990) (informed consent is personal to

involved in the protocols challenged by Plaintiffs are linked to antipsychotic medications and/or other medically approved procedures, rather than to the experimental portions of treatment. See Rivers v. Katz, 67 N.Y.2d at 490 n.1; A. 4 n.1.

In addition, the Appellate Division's strict application of the Storar doctrine only to "non-therapeutic" research (A. 40-44) is entirely inconsistent with that very line of cases. As Storar

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patient "unless by clear and questionable authority of law" permits otherwise); see also PHL § 2965(3)(c) (permits guardian of incapacitated person to execute a Do Not Resuscitate order in certain circumstances); A. 43 ("[t]he basic rule in New York is that *in the absence of specific legislation*, and where there is no evidence of personal intent, a surrogate has no recognized right to decide") (emphasis added).

This Court has also recognized on many occasions that a regulation that is duly promulgated has the force and effect of law. See, e.g., Molina v. Games Mgt. Servs., 58 N.Y.2d 523, 529 (1983) (a validly enacted regulation has "the force and effect of law"); and see Rahmey v. Blum, 95 A.D.2d 294, 298 n.1 (2d Dept. 1983) (regulations promulgated under federal statutes have the force and effect of law). OMH did promulgate surrogate decisionmaking regulations for human subject research, and included a provision honoring any surrogate's objection notwithstanding a consent by another surrogate. 14 N.Y.C.R.R. § 527.10(e)(2)(vii). This regulation would satisfy this Court's statements regarding legislation on surrogate consent. However, the Appellate Division invalidated the regulations, vitiating any need to engage in a constitutional analysis. Moreover, under PHL Article 24-A, which now governs, surrogate consent for minors and incapable adults to participate in research studies is insufficient. The Commissioner of Health and an independent human research review committee must also review and approve such studies.

Accordingly, the Appellate Division's analysis -- pegged to the invalidated regulations -- has no application in the context of the unchallenged Article 24-A oversight and in the absence of any regulations that this Court could review to determine whether they satisfy this Court's precedents.

and its progeny make clear, the degree of benefit that the patient derives from medical treatment is irrelevant to the question of whether a surrogate may consent to it. Fosmire, 75 N.Y.2d 218 (transfusion certain to save patient's life could not be performed over objection). In the context of life-and-death decisions, only the patient can direct the course of his/her treatment, regardless of the outcome. If Storar applies here, it could be read logically to prohibit all human subject research for those lacking capacity, independent of the recognized benefits. Such a result, however, is devoid of common sense, particularly in this setting where therapeutic research could be functionally the same as medical treatment. (A. 47); see also Pl. Br. at 14 ("incapable subjects of possibly therapeutic experiments are entitled to at least as much protection as are incapable recipients of medical treatment").

Moreover, Plaintiffs -- for several apparent reasons -- avoid any analysis of the actual research protocols they have challenged and the procedures that each one entails. In fact, each of the constituent parts of the ten challenged protocols may be consented to by a surrogate absent any need for court intervention.

Plaintiffs do not argue, for example, that a surrogate cannot constitutionally consent on behalf of an incapable patient to the administration of psychotropic drugs (even off-label prescriptions or FDA Investigational New Drugs) during the course

of psychiatric treatment, notwithstanding the risk of death or other physical impairment associated with such drugs. See PHL § 2504; cf. also Matter of Hofbauer, 47 N.Y.2d 648, 656 (1979) (parents' refusal to permit chemotherapy and radiation treatment, opting instead for laetrile injections and macrobiotic diet, could not be overridden by court notwithstanding risk of death to child because treatment was recommended by a physician and "has not been totally rejected by all responsible medical authority").

Nor do they argue that a surrogate cannot consent to a lumbar puncture, venipuncture, or rCBF outside of the research context. Likewise, Plaintiffs do not assert that advance directives or clear-and-convincing evidence is required generally before any of those actions may be taken vis-a-vis any incapable patient in an OMH facility, notwithstanding the risks and therapeutic benefits (or lack thereof) presented by each. See R. 99) (Complaint ¶ 17) (attacking "research *utilizing other treatments*, interventions, or procedures") (emphasis added). Nevertheless, Plaintiffs claim a constitutional right to, inter alia, notice and judicial review of even threshold psychiatric determinations, and of the surrogate's ultimate decision, if these elements are combined in a research study designed to benefit the patient and/or increase knowledge about the patient's condition in the context of a responsible risks-benefits analysis by the researchers, the IRB, and the surrogate.

There are without question risks involved in human subject research, and the overarching concern of New York's laws is to protect the subjects. See PHL §§ 2440, 2441(1). Yet Plaintiffs fail to distinguish between risks presented by research and risks associated with standard, approved therapies or medications. In fact, most of the protocols challenged here are either therapeutic or involve therapeutic elements combined with "non-therapeutic" (but standard) medical procedures, notwithstanding Plaintiffs' rigid attempts to classify them otherwise.

As the Appellate Division itself recognized, therapeutic research may be the functional equivalent of treatment for these patients. (A. 47). And, for the ten protocols specifically challenged by the Plaintiffs, each component of the research project could be authorized by a surrogate empowered by existing law to consent to those medical procedures either for minors or incapable adults. See, e.g., PHL § 2504. Accordingly, surrogate consent, accompanied by additional protections for the research subject (including withdrawal from protocol upon objection) is constitutionally adequate. As such, the court's misguided analysis should not be further extended to human subject research not governed by the invalidated OMH regulations.

B. The Appellate Division's Analysis as Applied to Minors is Flawed, and Highlights the Weaknesses in its Approach

For the same reasons articulated above, the Appellate Division's blanket prohibition against non-therapeutic more-than-

minimal-risk research involving minors -- while permitting therapeutic research upon parental informed consent -- is neither supported in the constitution nor mandated by it. In addition, the Appellate Division's conclusion that an IRB may never permit waiver of parental consent requirements, unless there is a finding of abuse and neglect under the Family Court Act, contradicts both logic and the law of this State.

1. The Appellate Division's Parental Consent Analysis is Internally Inconsistent and Contradicts its Conclusions Regarding Surrogate Consent for Incapable Adults

The rule in New York is clear that a parent may not consent to withdraw or withhold life-sustaining treatment for a minor. See Storar, 52 N.Y.2d at 380 ("[t]he parent . . . may not deprive a child of life saving treatment, however well intentioned"); see also Jehovah's Witnesses v. King County Hosp. Unit, 390 U.S. 598 (1968) (same under federal constitution). For the reasons articulated above, however, therapeutic and non-therapeutic research are not analytically the same as termination of life-sustaining treatment. Rather, the Appellate Division recognized that therapeutic research is tantamount to treatment for some of these patients (A. 47), and many of the constituent elements of so-called "non-therapeutic" research actually and directly benefit the subjects.[28]

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[28] The approach advocated by Plaintiffs in this regard also ignores the fact that data about drug safety and efficacy cannot be extrapolated from adults to children. See B. Vitiello & P. Jensen, "Medication Development and Testing in Children and

In this regard, a parent may consent to medical and health services on behalf of a minor child (PHL § 2504), even if those services represent unconventional forms of treatment.[29] "What constitutes adequate medical care . . . cannot be judged in a vacuum free from external influences, but, rather, each case must be decided on its own particular facts. . . . [G]reat deference must be accorded a parent's choice as to the mode of medical treatment to be undertaken and the physician selected to administer the same." Matter of Hofbauer, 47 N.Y.2d at 655-56;

Adolescents," Archives of General Psychiatry, Vol. 54 (Sept. 1997).

With regard to the human subject research conducted under the federal regulations or Article 24-A, each protocol is initially approved by a panel of several medical professionals including physicians and psychiatrists duly licensed to practice in New York. See, e.g., PHL § 2444 (human research review committees); 45 C.F.R. §§ 46.107, 46.108, 46.109 (composition, function, and research protocol review by Institutional Review Boards); id. § 46.406 (non-therapeutic research on minors may not present more than a minor increase over minimal risk); id. § 46.407(more than a minor increase over minimal risk for non-therapeutic reserch only under rigorous review process under auspices of Secretary of HHS). Those protocols are then regularly reviewed by trained professionals, in addition to the constant monitoring of the licensed phsycians and psychiatrists who conduct in the studies. See also (R. 2636-2675) (listing members of OMH IRBs, their academic degrees, and specialties).

[29] See Matter of Hofbauer, 47 N.Y.2d at 655 (parents "may rely upon the recommendations and competency of the attending physician if he or she is duly licensed to practice medicine in this State, for 'if a physician is licensed by the State, he [or she] is recognized by the State as capable of exercising acceptable clinical judgment'") (quoting Doe v. Bolton, 410 U.S. 179, 199 (1973)); Matter of Lori M., 130 Misc.2d 493, 495 (Sup. Ct. Richmond Co. 1985) (parental right to raise children "is of constitutional dimension and is, itself, entitled to protection") (citing Pierce v. Society of Sisters, 268 U.S. 510 (1925)).

Storar, 52 N.Y.2d at 381 (citing Hofbauer); Matter of Matthews, 225 A.D.2d 142 (3rd Dept. 1997) (same); see also Parham v. J.R., 442 U.S. 584, 603 (1979) ("Simply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state").

The Appellate Division's constitutional analysis fails to adhere consistently to any of the principles in Storar or Hofbauer. Because human subject research is analytically similar to medical treatment, parents have the right by statute and under the common law to direct the mode of care their child receives, as long as that care "has not been totally rejected by all responsible medical authority." Matter of Hofbauer, 47 N.Y.2d at 656; cf. also Matter of Barbara C., 101 A.D.2d 137 (2d Dept. 1984) (per curiam) (court hearing is unnecessary to validate surrogate consent to abortion properly exercised on behalf of mentally incapacitated woman under Mental Hygiene Law and its regulations).

The Appellate Division, however, permits surrogate consent for therapeutic research on minors without judicial review, and prohibits it for incapable adults unless there is an opportunity for judicial review of the capacity assessment and the surrogate's decision. Plaintiffs now ask this Court to extend this internally inconsistent approach to all human subject research involving minors, which this Court should decline to do

in the absence of a full factual record with regard to specific research protocols involving minors.

2. The Appellate Division Erroneously Concluded that Parental Consent Waivers Can Only Be Exercised After a Judicial Finding of Abuse and Neglect

The Appellate Division held that an IRB may waive the requirement of parental consent for a minor's participation in research only after a court has made a finding of parental abuse and neglect (thus terminating the parents' rights). The court reached this conclusion without any evidence in the Record regarding the types of research that would permit waiver of parental consent, and in disregard of the provisions of the invalidated OMH regulations at issue. More importantly, neither Article 24-A nor the federal regulations contemplate such research. Cf. Matter of Lori M., 130 Misc.2d at 496 (court would not declare minor to be a "person in need of supervision" under Family Court Act for exercising her privacy right to express her sexual orientation).

The Appellate Division ignored the express provisions of the invalidated OMH regulations, which limit a parental consent waiver only to those protocols where a parental consent requirement is unreasonable to protect the patient. Section 527.10(e)(3)(iii) permits parental consent waivers, and Section 527.10(e)(1)(iii)(a) permits an IRB to "approve a consent procedure . . . which alters some or all of the elements of informed consent" only if, inter alia, the research involves no

more than minimal risk to the patient. However, neither the regulations nor the Record indicate the types of protocols that have involved either provision, or if the provisions must be read together. The protocols Plaintiffs attack here would seek the assent of a minor for research that has, in practice, involved only risks which are not greater "than those ordinarily encountered in daily life." 14 N.Y.C.R.R. § 527.10(c)(6). Generally, these have included questionnaires and discussions about things that a child may not have disclosed to the parent, such as homosexuality or pregnancy. See Delano dep., at 91-102 (Feb. 11, 1992) (excerpts included in the Record exclude all but two of these pages).

In any event, the judicial procedure Plaintiffs seek is, at best, short-sighted because the minor will be exposed to the very danger sought to be avoided: at the judicial hearing, the nature of the research project must be discussed, and issues that the minor may not want to disclose to his/her parents will be exposed. Cf., e.g., Ohio v. Akron Ctr. for Reprod. Health, 497 U.S. 502, 512-13 (1990) (need for confidentiality in parental consent bypass proceedings) (citing Bellotti v. Baird, 443 U.S. 622 (1979)); Hodgson v. Minnesota, 497 U.S. 417, 460 (1990) (O'Connor, J., concurring) (parental bypass following judicial finding of abuse and neglect effectively notifies parents of minor's decision to have abortion).

This issue, however, is simply not presented by Article 24-A

and the federal regulations,[30] which unambiguously require parental consent. See PHL § 2442 ("consent *shall* be subscribed to in writing by the minor's parent or legal guardian") (emphasis added); 45 C.F.R. § 46.404 (requires parental consent even for research involving only minimal risk). Under the federal regulations, waiver of parental consent for research is permitted only if the parental consent requirement is unreasonable and "*an appropriate mechanism for protecting the children*" is substituted. Id. §§ 46.116(d)(1), 46.408(c) (emphasis added); see also A. 48 ("OMH regulations unlawful because they allow for an "ex parte determination by the IRB to consent with parental or guardian consent"). Plaintiffs fail to explore -- and the Record

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[30] As the Legislature recognized when it exempted federally regulated research (PHL § 2445), the federal regulations themselves protect the rights of minors involved in human subject research. Specifically:

(1) greater than minimal risk studies on minors will be permitted only if benefits outweigh risks, the risk-benefit ratio is the same as that presented by available alternative approaches, parents consent, and children assent. 45 C.F.R. § 46.405.

(2) research involving minors that does not hold out the prospect of direct benefit will ordinarily be permitted only if the risk represents "a minor increase over minimal risk," the procedure is commensurate with their physical and/or psychological situation, the study will yield knowledge about the child's disorder, parents consent, and children assent. 45 C.F.R. § 46.406.

See generally 45 C.F.R. Part 46 Subpart D ("Additional Protections for Children Involved as Subjects in Research"); see also 45 C.F.R. § 46.408 (outlining specific procedures necessary to secure parental consent and assent by child).

contains no information about -- the adequacy of those mechanisms. In the absence of such information, this Court should decline to require a judicial finding of abuse and neglect before any waiver of parental consent. The result is, quite simply, not mandated by the constitution and is not supported by common sense.

C. The Appellate Division's Articulated Constitutional Concerns Are Specific to the Invalidated OMH Regulations And Are Not Presented by the Other Regulatory Schemes

The Appellate Division articulated its concerns with specific portions of the invalidated OMH regulations as applied to incapable adults, and did *not* link them to human subject research generally:

(1) the regulations permit inclusion of minors and incapable subjects in research studies if surrogate consent is obtained (A. 38);

(2) the regulations do not require any type of qualifications to assess capacity (id.);

(3) the regulations do not specify a protocol on how to assess capacity (id.);

(4) the regulations do not mandate notice to the patient that his/her capacity is being questioned (id.);

(5) the regulations do not mandate notice to the patient that (s)he is involved in a research study (A. 45);

(6) the regulations do not provide for a judicial process so that a patient can challenge a finding of incapacity or the surrogate's decision (A. 38-39, 42);

(7) the regulations fail to recognize the potential conflict of interest in permitting the researcher to assess capacity without independent oversight (A. 39-40); and

(8) the regulations permitting override of a subject's objection are constitutionally inadequate (A. 50).

None of these concerns, however, is presented either by Article 24-A or by the federal regulations. Accordingly, the principles and procedures developed by the Appellate Division should not be adopted to govern human subject research generally, nor should they apply to research (federally funded or otherwise therapeutic research) that was explicitly excluded from the scope of the decision. Specifically:

(1) PHL § 2444(3) prohibits inclusion of, inter alia, minors and incapable adults absent consent from the Commissioner of Health and an independent human subject research review committee; 45 C.F.R. § 46.102(c) (defining "legally authorized representative" as those "authorized under applicable law to consent on behalf of a prospective subject"); id. § 46.111(b) requiring IRB to ensure that additional safeguards are in place for research involving children or the mentally disabled);

(2) PHL § 2441(6) defines the term "researcher" to include only persons licensed under the Education Law Tit. VII to perform diagnoses, treatment, medical services, etc., and PHL § 2444 establishes human research review committees at every facility where human subject research occurs, and specifies the composition of those committees; 45 C.F.R. § 46.107 (qualifications for IRB membership); id. § 46.107(a) (IRB must assess protocol in terms of standards of professional conduct);[31]

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[31] Plaintiffs cite protocols where, allegedly, capacity determinations were made solely by researchers. (Pl. Br. at 12). However, the referenced protocols do not permit surrogate consent, and in some cases the researchers are not the only ones authorized to assess capacity. See, e.g., R. 182-83: Iminaprine for Depressed Drug Users (in addition to individuals named on protocol, four others authorized to assess capacity); R. 422, 442: A Biochemical and Behavioral Study of Suicide and Aggression (only patients with capacity can participate, because study contemplates only written informed consent from patient,

(3) PHL § 2441(5)(a)-(f) sets forth those elements that a patient must be deemed to understand in order to provide informed consent; 45 C.F.R. § 46.116 (same);

(4) As will be demonstrated, infra at 60, notice of a question about the patient's capacity is an illusory safeguard of constitutional rights;

(5) PHL § 2441(a) requires "a fair explanation to the individual of the procedures to be followed, and their purposes, including any procedures which are experimental"; 45 C.F.R § 46.116 ("[a]n investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate");

(6) A judicial hearing created to cement a constitutional doctrine on human subject research does not advance the interests of OMH patients. These Plaintiffs can block any particular research study from proceeding simply by petitioning the court and presenting sufficient evidence about the study and its relative risks and benefits. See Matter of Robert C., 167 Misc.2d 677, 685 (Sup. Ct. New York Co. 1995) (civilly committed mental patients "can challenge certain administrative decisions . . . by CPLR Article 78 proceedings"). That process is the proper vehicle for a court to decide whether to ban a human research study, rather than imposing a blanket prohibition at the outset without any facts to support that approach.

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and no surrogate consent indicated), R. 446 (no surrogates designated for those who may be unable or incompetent to understand the study); R. 776-77: Fluoxetine Treatment for Methadone Maintenance Patients with Depression or Cocaine Abuse (seven additional people listed to assess capacity), R. 805 ("Subjects will be informed of these potential concerns and will give informed consent before entering the study"); R. 807-827: Haloperidol Blood Levels and Effects in Schizophrenia (not selected by Plaintiffs as one of the ten protocols approved for incapables); R. 1457: Nortyptiline Effects in Performance of Elderly Depressed (requiring informed consent in writing from the patient), R. 1470 (informed consent form contains no surrogate consent provision).

(7) PHL § 2444(1) provides that

> [n]o member of a [human research review] committee shall be involved in either the initial or continuing review of an activity in which he has a conflicting interest, except to provide information required by the committee. No committee shall consist entirely of persons who are officers, employees, or agents of, or who are otherwise associated with the institution or agency, apart from their membership on the committee, and no committee shall consist entirely of members of a single professional group . . .

See also 45 C.F.R. § 46.107(e) (same).

(8) The OMH provision at issue was entirely consistent with the doctrine in Rivers v. Katz, see infra, and in any event, neither Article 24-A nor the federal regulations permits or provides for an objection override.

In sum, assuming that constitutional deficiencies exist in the invalidated OMH regulations, they are not presented by Article 24-A or the federal regulations. Accordingly, human subject research conducted under either of those schemes should not be subject to judicial review procedures designed for the invalid OMH regulations.

D. The Objection Override Provisions are Entirely Consistent with Established Precedent of this Court.

This Court in Rivers v. Katz stated that

> in situations where . . . the patient refuses to consent to the administration of antipsychotic drugs, there must be a judicial determination of whether the patient has the capacity to make a reasoned decision with respect to the proposed treatment. . . . The State would bear the burden of demonstrating by clear and convincing evidence the patient's incapacity to make a

> treatment decision. . . . If . . . the court concludes that the patient lacks the capacity to determine the course of his own treatment, the court must determine whether the proposed treatment is narrowly tailored to give substantive effect to the patient's liberty interest . . .

67 N.Y.2d at 497 (emphasis added). The situation contemplated by Rivers involves active objection by the patient, and the protection of the patient's due process rights in administering medical care over that objection. See also Riggins v. Nevada, 504 U.S. 127 (1992); Washington v. Harper, 494 U.S. 227 (1990).

In the case of human subject research -- which should be governed by the same informed consent rules that apply to medical treatment -- patient objection to participation must be treated as in Rivers, including all the procedural safeguards such as notice and judicial review. Defendants certainly do not dispute that the procedure in Rivers applies whenever an incapable patient objects to participation, whether federally-funded or not. Concomitantly, however, where a patient does not object to participation, the judicial procedure of Rivers is not invoked.

Accordingly, judicial review is not mandated to test the facility's conclusion that the patient is incapable, nor is it necessary for research under Article 24-A or the federal regulations, where patients are informed of the research and its risks and benefits, and explicitly told that they can withdraw from participation at any time. PHL § 2441(5)(f); 45 C.F.R. § 46.116(a)(8).

Moreover, the judicial review process envisioned by the Plaintiffs for all human subject research provides only illusory protections. For example, Plaintiffs are seeking judicial review of all capacity determinations for therapeutic research. A patient who is deemed incapable (but who is in fact capable) receives little additional meaningful protection from judicial review, because (s)he can at any time discontinue participation in research. If the research provides a prospect of direct benefit not otherwise available to the patient, the OMH facility may petition a court under Rivers v. Katz to order the medication/monitoring involved in the research. Thus, the existing structure adequately protects patients.

By contrast, however, Plaintiffs do not seek judicial review on behalf of patients deemed capable to consent. A patient who is deemed capable (but who is in fact incapable), however, may be providing consent to something (s)he does not in fact understand without any of the oversight Plaintiffs demand. The logical (and intellectually honest) conclusion of Plaintiffs' request to extend the Appellate Division's constitutional analysis to all human subject research would require the courts, therefore, to revisit *every* capacity determination for patients in OMH facilities, and then revisit all surrogate consent decisions that follow. This scheme would effectively halt all human subject research in New York, to the detriment, primarily, of the

patients who benefit directly from the research and from the knowledge gained through research.

The Appellate Division wrongly concluded that "the [OMH] regulations were drafted to provide maximum flexibility in the assessment of capacity with the primary consideration being the researchers' need to determine an individual patient's suitability for the specific study involved." (A. 40). The Record simply does not support that conclusion. If the determination of capacity is to have any meaning at all, the "primary consideration" must be the *individual patient's* need to understand the elements of informed consent as to the particular protocol for which (s)he is a proposed participant. Any other view of capacity puts the individual at risk of "consenting" to participate in research whose nature, risks, benefits and alternatives (s)he does not understand.

E. Plaintiffs' Remaining Constitutional Arguments Are Without Merit.

Plaintiffs' argument that research conducted in accordance with the federal regulations violates the Equal Protection Clause of the United States Constitution is utterly without merit. The federal regulations are not only consistent with the common-law rules on surrogate consent, but also provide additional protections for minors and incapable adults. Moreover, the Record, like Plaintiffs' complaint, is devoid of any allegations and/or evidence -- including any indication as the relevant

similarities in the type of research and potential differences in the patient populations selected to participate -- to support the Equal Protection claim raised at this late stage. As such, this Court should reject Plaintiffs' arguments. See Gagliardi v. Village of Pawling, 18 F.3d 188, 193 (2d Cir. 2d Cir. 1994) ("[t]o establish such intentional or purposeful discrimination, it is axiomatic that a plaintiff must allege that similarly situated persons have been treated differently. . . . In the absence of any such factual allegations, the [plaintiffs'] equal protection claim is insufficient as a matter of law"). Plaintiffs' remaining claims, including a claim for involuntary servitude under the Thirteenth Amendment, should likewise be rejected.

CONCLUSION

For the above-stated reasons, the order and judgment appealed from should be affirmed solely upon the ground that OMH lacked the statutory authority to promulgate the challenged regulation. This Court should decline to extend the Appellate Division's erroneous constitutional analysis beyond its own reach to federal regulations and Article 24-A, which were not challenged in the Plaintiffs' Complaint and do not present the same problems allegedly presented by the invalidated OMH regulations.

Dated: New York, New York
October 30, 1997

Respectfully submitted,

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State of New York
Court of Appeals

"Amicus" filed

No. 252

T.D., et al.,

Appellants,

v.

The New York State Office of Mental Health, et al.,

Respondents.

MEMORANDUM

This memorandum is uncorrected and subject to revision before publication in the New York Reports.

Ruth Lowenkron, for appellants.
Lucia M. Valente, for respondents.
Bazelon Center for Mental Health Law, et al.; Associated Medical Schools of New York; American College of Neuropsychopharmacology, et al.; American Psychiatric Association, et al.; and Greater New York Hospital Association, amici curiae.

MEMORANDUM:

The appeal should be dismissed without costs.

In bringing this action, plaintiffs sought to have declared invalid regulations promulgated by defendant New York State Office of Mental Health (OMH), pertaining to experimental medical research on patients or residents of OMH facilities

deemed incapable of giving consent. Plaintiffs have received the complete relief sought in this litigation. A successful party who has obtained the full relief sought is not aggrieved, and therefore has no grounds for appeal (CPLR 5511; Parochial Bus Sys., Inc. v Board of Educ., 60 NY2d 539, 544-545; Matter of Bayswater Health Related Facility v Karagheuzoff, 37 NY2d 408, 412-413).

We note moreover that, once the Appellate Division in its decision below had concluded that the challenged regulations were invalid because OMH lacked statutory authority to promulgate them, it was unnecessary under the circumstances here presented to prospectively declare the regulations invalid on additional common-law, statutory, and constitutional grounds. In doing so, the Appellate Division issued an inappropriate advisory opinion (see, Cuomo v Long Is. Lighting Co., 71 NY2d 349; New York Pub. Interest Res. Group v Carey, 42 NY2d 527; Matter of State Indus. Commn., 224 NY 13).

Since plaintiffs are not aggrieved, and defendants have not cross-appealed, the appeal must be dismissed.

* * * * * * * * * * * * * * * *

Appeal dismissed, without costs, in a memorandum. Chief Judge Kaye and Judges Titone, Bellacosa, Smith, Levine, Ciparick and Wesley concur.

Decided December 22, 1997

Remittitur

Court of Appeals
State of New York

The Hon. Judith S. Kaye, Chief Judge, Presiding

1 No. 252
T.D., et al.,
Appellants,
v.
The New York State Office of Mental Health, et al.,
Respondents.

The appellants in the above entitled appeal appeared by Ruth Lowenkron, Esq.; the respondents appeared by Hon. Dennis C. Vacco, Attorney General of the State of New York and the amici curiae appeared by Stein & Schonfeld; Esqs.; Steven H. Mosenson, Esq.; Hinman Straub Pigors & Manning, Esqs.; Lori R. Levinson, Esq.; and Pepper Hamilton & Scheetz, LLP.

The Court, after due deliberation, orders and adjudges that the appeal is dismissed, without costs, in a memorandum. Chief Judge Kaye and Judges Titone, Bellacosa, Smith, Levine, Ciparick and Wesley concur.

The Court further orders that this record of the proceedings in this Court be remitted to the Supreme Court, New York County, there to be proceeded upon according to law.

I certify that the preceding contains a correct record of the proceedings in this appeal in the Court of Appeals and that the papers required to be filed are attached.

Stuart M. Cohen
Stuart M. Cohen, Clerk of the Court

Court of Appeals, Clerk's Office, Albany, December 22, 1997