A meeting of the National Research Ethics Advisors' Panel held on:

Date: **14 July 2010**
Time: **14:00 – 17:00**

Venue: Conference Room
Indian YMCA
41 Fitzroy Square
London W1T 6AQ

MINUTES

Present:

Andrew George (Chair)
Jeremy Butler
John Saunders
Nalin Thakker
Richard Tiner
Art Tucker
Frank Wells
Sue Wilson
Simon Woods

In attendance:

Dr Janet Wisely
Mr David Anderson-Ford (Chair, Association of Research Ethics Committees)
Mr Clive Collett (NREAP Manager)

1. Apologies: Sarah Dyer, Charles Warlow; Peter Heasman; Hugh Davies
2. Declarations of Interest

   There were none
3. Minutes of meeting held on 09 June 2010

   The minutes of the previous meeting were agreed as a true record.

4. Matters Arising

4.1 The pharmaceutical industry and Q A14-1

- Received for Information: email sent by Jeremy Butler (JB) to Kay Steele following the NREAP discussion of this issue at the June meeting

JB informed the committee that he had not received a response to his e-mail from Kay Steele.

Whilst JB was happy to have the contents of the e-mail circulated more widely it was noted by Janet Wisely (JW) that the e-mail simply confirmed existing policy with regard to patient involvement and that if members wish to take this issue to other bodies then it would be better to simply refer to this existing

policy and the Research Governance Framework statements regarding the involvement of patients in the design of clinical research.

4.2 Nuffield Consultation on Ethics of Human Bodies in Medicine and Research

- Received for Information: The final submitted NREAP response to the Nuffield Council on Bioethics consultation document “Human Bodies in Medicine and Research”.

The panel thanked Simon Woods (SWo) for his work in putting together this response on behalf of the panel.

4.3 Withdrawal of Data Following Participation in a Study.

- Received for Information: email from Andrew George to Professor Janet Darbyshire (Head of the MRC Clinical Trials Unit and Joint Director of NIHR CRN CC) about the Panel's concerns regarding the removal of data from research studies.

JW informed the panel that advice had been reported which referenced the requirements of the EU Clinical Trials Directive to retain integrity of trials data. There were interpretations to be made but current advice was that integrity of trial data needed to be considered alongside interpretation of data protection issues.

The panel discussed whether NRES or the NREAs should issue advice on the issue of the retention of data following the withdrawal of a participant. The panel agreed that the panel should review the current IRAS form and guidance and this issue should be discussed at a future meeting.

Action: CC

5. Mr David Anderson-Ford (Chair, Association of Research Ethics Committees)

- Mr David Anderson-Ford attended the meeting and gave a short presentation on AREC

6. NREA Guidelines: Addenda to Information Sheets – Janet Wisely

The panel were asked to note the applicant’s concern and make recommendations to inform development of guidance for consideration at a further meeting.

- Received and discussed: Addenda to Participant Information

The panel discussed the paper presented by JW and sympathised with the concern expressed by researchers that RECs were being inconsistent in this matter with one REC even reported to be suggesting that addenda may not be used "as a matter of policy". It was noted by the panel that there was no such NRES ‘policy’ regarding the use of addenda.

The panel considered that RECs had a responsibility to promote best practice with regard to the provision of relevant information in a timely manner to research participants. The prime ethical issue in such circumstances was the provision of important new information to research participants as quickly as possible and that it was not helpful to hinder this by entering into a prolonged debate regarding the specific format of the information or by prohibiting certain formats such as addenda to information sheets.

The panel agreed that there was a requirement for guidance to help committees decide on the basis of the new information how choices for participants are presented and managed. Clive Collett (CC) would liaise with Hugh Davies (HD) to put together an initial paper for discussion at a future meeting with a view to signing off the guidance at the September meeting.

Action: CC & HD

7. **Patient Information Sheets – Discussion Document** – Andrew George

The panel were asked whether they should develop guidance on Participant Information Sheets (PIS) and whether they could be shortened and/or made more accessible.

- Received and Discussed: Patient Information Sheets – Discussion Document

AG explained that whilst he did not think it was necessary for the panel to issue separate guidance on information sheets that it was helpful for the NREAs to discuss the issues and provide advice to NRES regarding changes that might be made to existing guidance/templates etc.

AG stated that anecdotal evidence suggested that information sheets were often too long and could compromise the efficient provision of information to potential participants rather than facilitate it. He wished to start a conversation about what information really needs to be in information sheets. David Anderson-Ford (DAF) explained that there had been recent papers submitted to the Academy of Social Sciences that had shown that participants pay less attention to written information sheets than they do to their relationship with the researcher and the trust that they have in them. DAF agreed to forward the references for these papers.

It was noticed that currently NRES provide guidance in the form of the "NRES guidance on information sheets and consent forms version 3.5 (May 2009)"[1] and the leaflet "Explaining Research"[2]. In addition paragraph 4.8.10 of the ICH GCP guidelines[3] stipulates 20 items that should be included in both the informed consent discussion and the written informed consent form.

Sue Wilson (SWi) commented that she shared frustration with lengthy information sheets and stated that there was little published research literature regarding what potential research participants actually want to know before deciding whether or not to take part in research. She noted that much of the information sheet guidance currently published was produced by the "great and the good" and not based upon the views of patients and participants. In her own research she has found that around 30% of people do not wish to read the information sheet at all. She is currently conducting research regarding what information patients actually want to know. The panel agreed that an evidence-based approach would be extremely useful in producing any authoritative guidance on this matter.

SWo noted that there had been a recent shift in the legal interpretation of what constituted an appropriate level of information away from the traditional 'Bolam' standard, measured against the relevant reasonable body of professional opinion, towards a more patient centred 'reasonable person' approach. However, while this was to be welcomed many patients themselves do not know what information they would like to have nor do many patients clearly understand concepts such as 'placebo' and 'randomisation' in research. He emphasised that there was a real need to develop information material that was fit for purpose and prudent, evidence-based information guidance.

Richard Tiner felt that, whilst on balance shorter information sheets were better than lengthy ones, it was important to remember that the introduction of the NRES information sheet template has made a considerable difference to the consistency and quality of information sheets and has helped to remove some of the inconsistency of RECs in reviewing them.

The panel discuss the possibility of "user testing" of information sheets prior to their submission to RECs. It was agreed that this could be an extremely useful technique and was consistent with the important principle of increasing involvement of patients in the design of research studies. Furthermore,

[1] http://www.nres.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=338&type=full&servicetype=Attachment
[2] http://www.nres.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=356&type=full&servicetype=Attachment
[3] ICH Topic E 6 (R1) Guideline for Good Clinical Practice - NOTE FOR GUIDANCE ON GOOD CLINICAL PRACTICE (CPMP/ICH/135/95) - July 2002. http://www.ema.europa.eu/pdfs/human/ich/013595en.pdf

this would make it difficult for a REC to reject an information sheet that had been developed with the co-operation and input of the study's target audience.

John Saunders stated that information sheets merely need to be sufficient and adequate, presenting the broad nature and purpose of the study in order for an individual's consent to be valid. In everyday life most of us do not read the "small print" of airline tickets or computer software and yet our acceptance of the terms and conditions of such items were still considered to be valid. He emphasised that the NRES template is simply a guide to the information that needed to be included and not a condition of approval. There may often be occasions where the template is not the most appropriate format for the type of study under consideration by a REC. Nalin Thakker (NT) agreed stating that the template was not the problem rather it was RECs insistence on it being used even in cases where it was clearly not entirely relevant.

In summary, the panel agreed that there were three themes that had emerged from the discussion which would be useful to pursue:

1. **User involvement** – Draft information sheets could be developed with and tested by the target audience for them prior to submission. Existing guidance to researchers and the IRAS form (e.g. Q A14-1) could be modified to promote this as good practice.
2. **Research**. The panel suggested that there is a very real need for basic research into what information is wanted and/or needed by potential research participants, how this is processed by them to reach a decision and the best format for conveying this information as efficiently as possible in order to provide valid consent. Such research could be used as the basis for the provision of authoritative evidence-based guidance. It was suggested that NRES might wish to consider commissioning such research.
3. **NRES information sheet template**. The panel felt that the current NRES template was extremely useful but could be used more judiciously by both researchers and RECs. It should be recognised that there are circumstances where following the template does not produce the optimal information sheet.

Of these three themes it was felt that the provision of guidance to RECs regarding the status of the current NRES template would be the easiest and quickest to move forward with to emphasise the need for a sensible interpretation of guidance. It needed to be made clear to RECs that the use of the template was not mandatory in all cases but that it simply provided a comprehensive set of questions for researchers to consider including in their information sheet.

JW explained that when the NRES template was issued it was always considered to be subject to continuous review and revision in the light of emerging research. JW suggesting inviting comments on the template from all stakeholders to inform its further development and formal review in 2011

8. **Translation of Information Sheets**

- Discussed: At the June NREAP meeting Sue Wilson raised the issue of the translation of information sheets, particularly for student research, or for a pilot study. She explained that RECs would often insist upon such translation even where the researcher had no budget to fund this. The Panel agreed that, whilst it acknowledged the importance of providing translated information documents and interpreters to non-English speakers and the importance of making access to research available to all members of society, there may be occasions where it would not be appropriate to insist upon this. The Panel agreed to discuss this issue further at this meeting.

SWi explained that she had encountered RECs who had insisted upon the translation of information sheets into the top five languages present in a population for a piece of student research on erectile dysfunction. She felt that this was not appropriate, particularly for student research, where there were not sufficient resources to do this. She was concerned that RECs could sometimes adopt a 'tick box

mentality' regarding the issue of translation whereby they would always insist upon it even when it was not really appropriate or feasible to do so.

JW explained that NRES did not have a policy requiring translation in all cases. Whilst applicants should always explain and defend their decision not to translate information sheets, RECs could not insist upon the provision of translated information or interpreters. This was a position that had been previously confirmed with DH.

JS explained that he had recently given a talk on the subject at a recent meeting in Wales. He recognised that this could be controversial but offered arguments that highlighted important issues in the debate. He stated that under one view of social contract theory if individuals do not fully participate in society (for example by not learning the predominant language) then there was no corresponding obligation to facilitate their involvement in activities such as research. Under this view there would be no need to translate information sheets unless there was a scientific need to do so. He further reminded the group that under the British Nationality Act 1961, British citizenship by naturalisation may only be granted to those who have a 'sufficient knowledge' of English, Welsh or Scottish Gaelic.

The contrary view, he stated was one based upon the principle of distributive justice, whereby the benefits and burdens of research should be shared equally amongst everyone likely to benefit from it. Adherence to this principle would demand that individuals should be given the opportunity to fulfil their obligation to contribute to, and share the burden of, research and where obstacles to their participation exists then these should be removed as far as is practically possible e.g. by the provision of translation services. Furthermore, he explained that, to put the issue of translation into context, little assistance was given to those who were dyslexic, deaf or blind (all of whom represented significantly larger groups than those who have difficulties with the English language) in order to fully participate in clinical research.

JS referred the panel to the following sections regarding this issue in the 'RCP Guidelines on the practice of ethics committees in medical research with human participants' and expressed the view that these might be commended by NRES and disseminated to RECs:

> "Information sheets
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> 5.46 Information giving may present particular problems to children, and to those with sensory impairments or language difficulties.
> 5.47 It has been estimated by the British Dyslexia Association that around 2 million (or approximately 4%) of the UK population are severely dyslexic (see: www.literacytrust.org.uk). In addition, those registered blind number 157,000 and those with significant visual difficulties over 200,000. Around a quarter of blind and partially sighted persons also have hearing loss.
> 5.48 Hearing impairment is also common. There are about 9 million deaf and hard of hearing people in the UK (55% of those aged over 60) with 698,000 people severely or profoundly deaf (www.rnid.org.uk).
> 5.49 Research participants with such sensory difficulties are often overlooked by RECs. These problems are more common than those of the non-English speaker. They can be addressed by use of visual or audio recordings and we would encourage these techniques to be more widely considered. In general, the outlay should be small and within the budget of most research projects.
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> Language
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> 5.50 Apart from the special case of Welsh and the provisions of the Welsh Language Act, the ethically important issue with language is the failure to understand English, rather than the first language of the participant. Many professional translators, for example, may not speak English as a first language.
> 5.51 Estimates of the numbers of people in England who have difficulties with the English language vary widely from 400,000 to 1.7 million. In the case of adult refugees, for example the ability to understand spoken English is more often absent than present. This inability is a key barrier to citizenship under the British Nationality Act 1961, to employment, education,

access to services and to a full role in society. The latter includes participation in research.
5.52 Where translation is necessary for informed consent or other aspects of a research study, accredited translators should be used wherever possible, ideally trained to the Institute of Linguist's (www.iol.org.uk) Diploma in Public Service Interpreting (DPSI) standards or equivalent.
5.53 Investigators working with interpreters may themselves need a short training course to achieve best practice. For example, use of translators inevitably involves the disclosure of information to third parties. The investigator must therefore begin by assuring the patient of the confidential nature of the exchange and seeking consent to the use of the translator.
5.54 Telephone interpreting interrupts flow and is not conducive to rapport; nor does it allow any checking on the quality of the translation. On the other hand, the anonymity of a telephone translator may be comforting in small or closely knit ethnic communities, where the presence of a potentially known third party may inhibit communication. Details are available from 'Language Line Services' (www.languageline.co.uk)
5.55 The use of family members raises similar concerns as the presence of a third party translator. Confidentiality is compromised and family members are often unprepared to deal with the complexity required by medical information. This may be compounded by the possibility that the translator may either persuade or dissuade participation rather than informing. The accuracy of the translation is one reason for using an accredited translator with DPSI qualification. (One study showed that between 23% and 52% of words and phrases were incorrectly translated by ad hoc interpreters.)
5.56 It is unreasonable to expect every research team to produce information in all languages spoken in multicultural Britain and, if necessary, to produce it on audiocassette where there is a chance that the potential participant may not be literate. A counsel of perfection will place an unrealistic burden on many research studies with limited resources. In particular, it is noted that many questionnaires may be validated in few languages or only in English. Demanding validation of such materials is not a realistic request for the REC to make and recruitment of participants may therefore need to be limited to those understanding English.
5.57 Ethnicity and the ability to speak English are, of course, separate. Nevertheless, the exclusion of non-English speakers may bias the study population and the validity of outcomes in some studies – for example, in surveys of use of healthcare resources.
5.58 In summary, it is a principle of distributive justice that benefits and burdens should be shared. While the inability to speak English may create a vulnerability that may be difficult to overcome, RECs should encourage pragmatic solutions that encourage investigators to adopt inclusive strategies of recruitment wherever possible, while acknowledging that the ideal may sometimes be impractical." [4]

JW felt that it might be useful for NRES to issue a letter confirming current NRES policy with regards to the consideration of translation of information sheets.

9. ANNUAL REPORTS 2009-2010 : COMPLAINTS, BREACHES AND APPEALS (submitted to April NRES DMG meeting)

- Received for Information: NRES ANNUAL REPORTS 2009-2010 : COMPLAINTS, BREACHES AND APPEALS

10. Review of NREAP Membership/Terms of Reference/Progress

- At the first meeting of the NREA panel it was agreed that the terms of reference and membership would be reviewed after 6 months and annually thereafter. The panel were invited to reflect upon

[4] RCP Guidelines on the practice of ethics committees in medical research with human participants (Fourth edition, September 2007) http://bookshop.rcplondon.ac.uk/contents/ed9115d9-7fea-445f-9b08-2fecf2b4107a.pdf

and discuss the current membership, terms of reference and progress made by the panel so far.

Terms of Reference of the National Research Ethics Advisors' Panel:

- Arbitration on ethical debates and disagreements arising from appeals by applicants and from within RECs.
- Oversight of the 'shared ethical debate' external quality assessment program for RECs.
- Oversight of NRES training programmes and training delivery as appropriate.
- Oversight of personal development programmes for REC chairs.
- Advice to NRES or RECs regarding alleged fraud or misconduct in research.
- Provision of guidance on governance issues and legal issues.
- Support for NRES with business planning and strategy.
- Support for NRES with relationships with RECs and support to RECs in their relationships with NRES.
- Support for NRES with relationships with other regulators, research funders, universities, professional bodies and industry including AREC.
- Support for NRES with patient and public involvement in research.
- Support for NRES with media enquiries and response to news items or journal articles about RECs.
- Representing NRES at events and conferences.
- Facilitating NRES events.
- Chairing ad hoc advisory groups and working parties as appropriate.

The panel noted that a potential panel member with legal expertise was to be interviewed shortly. Other than this area they felt that the current membership was sufficient.

The panel reviewed the existing terms reference and did not feel that there was need for any major revision.

JW explained that whilst there was still work to be done on how to link the role of the panel with the wider NRES team she was happy with the work of the panel so far. She felt that the panel represented a "collective sensible voice" and found it useful to be able to bring issues to the panel for discussion and advice.

11. **Any Other Business**

11.1 Equity and excellence: Liberating the NHS – Government White Paper[5]

JW updated the panel with regards to the impact on research of the recent Government white paper

[5] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117352.pdf

" Equity and excellence: Liberating the NHS". Overall she considered the paper to be generally positive with regards to research in the NHS:

> "**Research**
>
> 3.16 The Government is committed to the promotion and conduct of research as a core NHS role. Research is vital in providing the new knowledge needed to improve health outcomes and reduce inequalities. Research is even more important when resources are under pressure – it identifies new ways of preventing, diagnosing and treating disease. It is essential if we are to increase the quality and productivity of the NHS, and to support growth in the economy. A thriving life sciences industry is critical to the ability of the NHS to deliver world-class health outcomes. The Department will continue to promote the role of Biomedical Research Centres and Units, Academic Health Science Centres and Collaborations for Leadership in Applied Health Research and Care, to develop research and to unlock synergies between research, education and patient care."

She also noted that the paper highlighted the importance of patient involvement in research:

> 2.3 We want the principle of "shared decision-making" to become the norm: no decision about me without me. International evidence shows that involving patients in their care and treatment improves their health outcomes, boosts their satisfaction with services received, and increases not just their knowledge and understanding of their health status but also their adherence to a chosen treatment…This is equally true of the partnership between patients and clinicians in research, where those institutions with strong participation in clinical trials tend to have better outcomes.

It was also noted that the paper suggested that anonymised aggregate data might be made more accessible to researchers:

> 2.13 We intend to make aggregate data available in a standard format to allow intermediaries to analyse and present it to patients in an easily understandable way. Making aggregated, anonymised data available to the university and research sectors also has the potential to suggest new areas of research through medical and scientific analysis. There will be safeguards to protect personally identifiable information. We will consider introducing a voluntary accreditation system, which will allow information intermediaries to apply for a kitemark to demonstrate to the public that they meet quality standards.

The ongoing AMS independent review was also stated in the paper but it was noted that no timeframe was stated for this:

> 5.8 The Government will cut the bureaucracy involved in medical research. We have asked the Academy of Medical Sciences to conduct an independent review of the regulation and governance of medical research. In the light of this review we will consider the legislation affecting medical research, and the bureaucracy that flows from it, and bring forward plans for radical simplification.

12. **Date of Next Meeting:**

The next meeting of the National Research Ethics Advisory Panel will be held on 11 August 2010.
Time: 14:00 – 17:00.
Venue: Room 6, NPSA, Maple St, London