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Ethical considerations for consent for research in childhood populations
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Area of expertise (or may be regarded as a conflict of interest)

14 years of emergency care research in African children

At this point

- 'Vulnerability' is evident in all stakeholders: the child, the parents or guardians and the members of the medical profession (treating the child)
- Consent in this circumstance can never be considered as fully informed- and this probably extends to deferred consent.
- Families or carers often look to the medical profession for guidance and their expertise in critical decision-making for their child's health (the usual patient-doctor/nurse relationship)– but owing to the requirements for non-directive information giving, the nurses and doctors are put in very complex dilemma. I came across the following reflection, which I thought was very apt.

' If a patient (parent) trusts a doctor to prescribe a drug for which there is little evidence for benefit/superiority over another treatment (ie usual practice) so that trust should extend to a fully peer- reviewed trial, that has considered the balance of risk over benefits of the proposed interventions.'

Often it does not. Clinical trials still have negative connotations (exploitation, commercial gain etc)

The linked social science investigation of stakeholders views of assent/consent in the FEAST trial (Plos Medicine) highlighted some of these issues. Of note, many of the mothers/fathers had no formal education and little or no exposure to societal views about research or their rights as citizens/patients-proxies. I thought their views were extremely informative.

In summary,

Mothers concerns:

Too much information, too many decisions at a time when they felt under considerable emotional stress, husband is not present- they worried that if their child dies/has a poor outcome they will be blamed/beaten. I think this speaks to every parent who has made decisions about/for their child when the outcome of the decision may not have been as intended.

(An ethical process meant to protect exploitation/vulnerable populations that results in increased vulnerability could be deemed as completely not 'fit for purpose')

Health professional concerns

Verbal assent prior to informed consent or deferred consent is not a 'legal' process ie they felt vulnerable to being sued – even though they understood that there was ethical approval for this process. Fear often lead to negative

views about research. Which affects patient enrollment, either indirectly (ie eligible patients are 'overlooked') or directly (parents detect the hesitancy)

Informed consent- quite often parents will ask a clinician or nurses advise on whether to say they agree to join but they have been trained to not to be directive. (I have heard an example of an external audit of a clinical trial where the review team try to 'trick' nurses or doctors into making suggestions to parents seeking their advise on whether or not to agree to enrolment! This resulted in the study being temporarily halted!).

(We are dealing with human beings not automatons).

Societal perspective

Research should be a right and part of every day routine medical care and not an exceptional circumstance. (Peto R.)

Many treatments have remained within guidelines, often with a very weak evidence base, due to lack of appropriate and quality research. Many of these treatments are not cheap and many have harmful side effects.

The resources available to society are limited and therefore the prohibitive costs of clinical trials often means that most new treatments are tested on a limited number of participants. It may take many years to discover that some of these trials were either inadequate (design or size of effect), fraudulent or resulted in little benefit. For children single arm trials to extend drug licensure has become the norm rather than the exception.

My suggestions

Ethical research board approval rather than individual approval for research trials that involve emergency interventions should be the standard. A process should be available for opt out rather than opt in. This way new treatments and even old treatments can be tested in 'normal practice' (and involving randomisation) so long as they are deemed to have more likelihood to do benefit than harm. This puts the ethical and scientific obligation on the peer/ethical review process - who have access to all the data and can weigh this up and consider it a length – rather than the parent/clinician who does not.

Society and the medical profession should develop a rolling process/global adaptive design for testing all common clinical interventions (drugs and technologies) through a standard minimal data collection where randomisation occurs at a cluster level or at a national level. This would decrease the autonomy of doctors but opt out would be more time-consuming making this less attractive. Inferior treatments would be dropped out as newer ones are tested- everyone wins!

For rare conditions and novel 'first in humans' agents the old model is preferable. Huge randomized trials for the former, especially if the condition decreases lifespan, are likely to be of no benefit to an individual.

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