



Inside a research ethics committee

by Adam Jacobs

Any medical writer who has ever written a clinical study protocol will know how important it is to get the protocol ‘through ethics’. I’m sure all medical writers are aware how important it is for all clinical research to be done to high ethical standards, ensuring that the safety, privacy, dignity, and autonomy of research subjects are respected. But I suspect there are many medical writers who are less familiar with the mechanics of the ethical review process. For anyone who has ever wondered what happens to that protocol while it is on its journey ‘through ethics’, read on.

I have been a member of a research ethics committee for a little over 5 years, and in this article I shall share some of the knowledge I have gained of how the ethical review process works. I should point out that my experience is from a UK perspective. In theory, European directives should mean that the ethical review process is similar in all European countries. In reality there are no doubt a few differences, but I hope they are small enough that this article will be of relevance no matter where you are in Europe. If anyone has vastly different experiences in other parts of Europe, I’m sure they’d make an interesting contribution to a future issue of *TWS*.

The first part of the ethical review process is for the chief investigator to submit the application. Depending on the circumstances, this may be done via the central allocation system of the National Research Ethics Service (NRES), or directly to the appropriate ethics committee. There are complicated rules about this (and this is no doubt one of the parts that will vary from country to country) which can be found on the NRES website [1]. The main part of the application is the application form. This is a lengthy form, often running to 30 or more pages when printed out, and is the main document the ethics committee will review. There are other supporting documents that must be submitted with it, such as the protocol and, crucially, the patient information and consent form. When the application form was first introduced, it was extremely cumbersome and was quite rightly criticised for being too burdensome [2]. However, the process has been streamlined since then, and while it is still a substantial amount of work to complete an application form properly, it is a lot easier than it was. In its latest incarnation, introduced this year, it now takes the form of an online system known as the Integrated Research Application System (IRAS) [3]. IRAS takes the information filled in in various fields, and copies them to the relevant forms, so if more than one form is required, the information now only needs to be entered once.

Although the protocol is submitted as part of the application, it is important to realise that the ethical review will be based mostly on the application form. Some members of the committee may never read the full protocol. It is therefore essential that all important details that could possibly impact on the ethics of the study are included on the form. Ethics committees consist of a mixture of expert and lay members, and the lay members will struggle to understand

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the study if it is written in too technical a manner. The application form must be written so that it can be understood by a layperson, a point which many applicants seem to have great difficulty grasping.

So what are the main things that the ethics committee will consider when trying to decide whether a study is acceptable? We are, of course, very much guided by the ethical principles set out in the Declaration of Helsinki [4] (please note that a new version of the Declaration was released in October this year, so previous versions are no longer valid, see page 198). Patient safety is probably the most important, although this is less often a problem in practice than you might think, as most investigators are very well aware of the importance of patient safety and would not wish to design trials that put it at risk. Nonetheless, some more subtle points of safety may raise their head here, such as the use of X-rays or other forms of ionising radiation. A single chest X-ray, which gives a very low dose, is easy to justify, particularly if it contributes to the clinical management of the patient as well as the research. Something giving a higher dose of radiation, such as a full-body CT scan, would simply not be acceptable in healthy volunteers. If it is needed clinically, it is much easier to approve, and if the patients are elderly or severely ill such that their life expectancy is less than the time it typically takes for radiation-induced cancers to develop, then even very high doses of radiation may be acceptable.

Of course, no study is 100% safe for all research subjects. Investigators who claim their study has no risk are lying. Ethics committees accept that there are risks involved in research, but those risks must always be in proportion to the expected benefits.

Some procedures may not pose any significant risk to the health of the patient, but may nonetheless be unpleasant, painful, or uncomfortable. Arterial blood sampling, muscle biopsy, or endoscopy are all examples. There is generally

no ethical objection to those sorts of procedures, provided there is some suitable rationale for their use, and most importantly, the patients are fully informed of what to expect (see below). It would generally be appropriate for research subjects to receive some payment for undergoing such procedures if it is not a normal part of their clinical management (e.g. in healthy volunteers).

One area of frequent concern is privacy and data protection. Data about identifiable patients must be strictly controlled. We are not at all happy if researchers want to include patient names in their study database that they then keep on a laptop computer. While it is generally essential to record patient names somewhere in a clinical study, that record must be closely guarded, and ideally never leave the researcher's office. Most data kept in the study should be anonymised, with patients identified only by a number.

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Probably the area that my committee objects to more than any other is the patient information and consent form. It is absolutely essential that this be written in a manner that patients can understand and explains all the risks and discomforts of the study clearly and honestly. This is something that many investigators find difficult, and an area where medical writers who understand how to write for patients can make a really important contribution. I've written more about this extremely important part of the ethics process in a previous issue of *TWS* [5].

Most of my committee's objections are to patient information and consent forms

Freudian commas

I heard a news item on the radio recently, and judging from the way the item was read out, either the newsreader stumbled over his words, or whoever had written the script had been a little careless with punctuation. I believe the item should have been written "President Bush said he would send his Vice President, Dick Cheney, to Georgia." However, it sounded as if it had been punctuated as "President Bush said he would send his Vice President Dick, Cheney, to Georgia." Some may argue that the mis-punctuated version is spookily accurate, but I'm pretty sure it wasn't the message the writer meant to convey.

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I suspect that medical writers are not involved in the process of submitting studies for ethical approval as much as they should be. Many of the application forms I read are abominably badly written, with confusing language and copious linguistic errors that hamper their understanding. If they were compiled with the help of medical writers, I'm sure they would be a great deal easier to read. The need for experts in writing to help with patient information and consent forms is painfully obvious to anyone who has read some of the garbage that gets submitted all too often. Next time you are involved in writing a protocol, perhaps you could see if your help is needed with the rest of the ethics application?

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References:

1. <http://www.nres.npsa.nhs.uk/>
2. Wald DS. Bureaucracy of ethics applications. *BMJ* 2004;329:282-5
3. <http://www.myresearchproject.org.uk/>
4. <http://www.wma.net/e/policy/b3.htm>
5. Jacobs A. Patient information leaflets: the ethics committee view. *TWS* 2005;14(3):82

Joining an ethics committee

Information on how to join an ethics committee can be found at: <http://www.nres.npsa.nhs.uk/patients-and-the-public/get-involved/>

Ig Nobel Prizes for 2007

Keeping up the *TWS* tradition of reporting the annual Ig Nobel Prize awards, which have been described in *Nature* as "arguably the highlight of the scientific calendar," we are pleased to announce that details of the winners are now available on <http://improbable.com/ig/winners/>. The 2007 Ig Nobel Prize ceremony took place at Harvard University on 4 October 2008. The biology prize went to French veterinary researchers who established that dog fleas jump higher than cat fleas [1]. The medicine prize went to researchers from the US and Singapore who found that participants in a study rated expensive US placebo as more effective than cheap US placebo and cheap or expensive Chinese placebo. All participants were given the same placebo, which they were told was a new opioid analgesic [2].

References:

1. M.C. Cadiergues, C. Joubert, M. Franc. A Comparison of Jump Performances of the Dog Flea, *Ctenocephalides canis* (Curtis, 1826) and the Cat Flea, *Ctenocephalides felis felis* (Bouche, 1835). *Veterinary Parasitology* 2000;92:239-41.
2. Rebecca L. Waber; Baba Shiv; Ziv Carmon; Dan Ariely Commercial Features of Placebo and Therapeutic Efficacy. *JAMA*, 2008;299:1016-1017.