

**SCOPING STUDY TO EXPLORE THE MOST APPROPRIATE WAY TO PRODUCE AND
DISSEMINATE INFORMATION ON THE QUALITY OF RANDOMISED CONTROLLED TRIALS FOR
POTENTIAL PARTICIPANTS**

known as

PACT (Participants' Assessment of Clinical Trials)

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1. INTRODUCTION

1.1 Background to the commissioned study

The rapid pace of new developments in health care delivery poses both threat and promise to the NHS (1). If truly effective treatments are harnessed successfully, this has the potential for significant health gain; however, if ineffective treatments are diffused into the NHS, this will result in both inefficient use of health service resources, and also a detrimental effect on health. It is, therefore, important that new treatments and technologies undergo rigorous evaluation before their widespread introduction into the NHS (2;3).

Rigorous evaluation requires the participation of potential users of the treatments and technologies being evaluated. The randomised controlled trial (RCT) is widely accepted as the gold standard design for assessing the effects of new treatments, but researchers often find it hard to recruit enough participants to these trials (4). At the same time, some people who would like to enter RCTs are not offered the opportunity to do so.

A centralised resource that provides information about ongoing UK-based RCTs, and which is specifically orientated to the public, could help potential participants to identify which trials are ongoing, and/or find out more about the quality of these trials. At present, although there are a few registers of ongoing trials available, there is no

comprehensive resource which has been developed based on the types of information the public specifically want.

Consumers in NHS Research commissioned us to inform the development of such a resource by carrying out an up-to-date assessment of the types of information that are important to potential trial participants and appraising the ways in which that information could be provided. This assessment was to reflect the perspectives of: people who have recently been approached to take part in a trial, those actively looking to volunteer for a trial, consumer representatives, and the researchers who design and conduct such trials.

1.2 The nature of the problem

The question of what information should be provided to potential trial participants via a central information resource, and how, is related to, but not the same as, the question of what information should be provided to people who are being invited to participate in specific clinical trials. Both of these questions raise issues regarding what the information is going to be used for and how, what information people need, what constitutes informed consent, and how people should be encouraged to make decisions about trial participation.

There are several motivations for providing information:

- To encourage or persuade people to participate in a trial
- To enable people to decide for themselves whether or not they wish to participate?
- Trial sponsors and trialists may also require that certain information is provided to 'cover their own backs'.

Our own position, which is reflected in this report, is that potential trial participants should be given information that enables them to decide for themselves about whether or not they want to participate, although it may legitimately encourage people to consider the implications of the trial for wider society, as well as for themselves, before making their choice. In practice, the distinction between information that aims to persuade people to participate and information that aims to

enable people to decision for themselves about participation is difficult to make. The two are not entirely incompatible.

In this section, we briefly summarise key issues from the literature relating to informed consent and decisions about trial participation more generally.

Informed consent

Informed consent is difficult to define, and there are no easy answers to the question of what information is needed to support informed consent to trial participation because:

- Opinions vary as to which types or elements of information are required for 'informed' consent.
- The provision of information does not always result in comprehension of information.
- The way that information is presented is known to affect the ease with which information is understood and the way it is interpreted, but it is not clear which forms of presentation maximise understanding or are 'best' for informed consent.
- Objective and subjective assessments of information provision, knowledge and understanding do not always correlate well, and their relative importance is disputed.
- 'Consent' given at one point in time to participate in a trial is usually assumed to hold for the duration of a trial, but people may forget what they were told, knew or understood at the time of giving their consent.

It is generally accepted in the literature that people need to be given 'enough' information to enable them to make, or have a clear say in, decisions about their health care. Regulatory guidance and legislation has tended to favour maximum disclosure and require (or be interpreted as requiring) trialists to provide people with 'full' information whether or not the patients wish to receive it.

There are concerns, however, that people might be given 'too much' information and/or 'too much' responsibility for decision making. The feared adverse consequences are threefold;

- Causing harm to the patient through undue emotional distress - there are occasions when some consider that 'fully informed consent' is cruel and detrimental to patients (5),(6) - for example when a patient has just been diagnosed with a life threatening illness.
- Adversely affecting the patient/doctor relationship – for example, misunderstandings over the nature of the trial (and randomisation), or disappointment with the allocated treatment, can be distressing for the patient. A patient's trust and confidence in their doctor, and medical advice as a whole, may be lost (5),(6).
- Causing methodological compromise of the trial – In some situations, the provision of detailed information may make it difficult to keep participants 'blind' to their treatment allocation within a trial, and/or it may influence the outcomes of the treatments by modifying people's expectations and concerns. Similarly, full disclosure of the purpose of the trial and its design, has been shown to lead to various types of bias (7).

Debate in recent years seems to have led to a favouring of the view that, beyond a (disputed) minimum people should be as well informed as they wish to be (8). It is increasingly recognised that the information needs of people who are being asked to participate in a trial may vary according to the nature of their illness, the nature of the trial, the timescale that is available for decision-making, and their individual characteristics including current understanding, preferences for information, ways of coping, and preference for roles in decision-making.

Recognition of the diversity of individual information needs suggests that individually 'tailored' information might be preferable to routine 'maximum' disclosure of information to potential trial participants. The logistics of providing individually tailored information will vary according to the nature of the research.

Much of the debate about whether informed consent is cruel focuses on trials of treatments for acute, life threatening illness (particularly cancer) (5),(9),(10). This is a specialist sub-set of trials which would probably require specialised guidelines and mechanisms for providing tailored information. Other settings which face particularly

difficult issues in providing information to participants are those in which a person's capacity to hear, understand and interpret information for themselves is limited. These include emergency medical situations (6), conditions affecting the elderly (6), when a person is unconscious (11), when a person is unable to provide informed consent (e.g. sufferers of Alzheimer's) (11) and the use of discarded or unwanted tissue/body parts (12),(11).

Understanding of the concept of informed consent has shifted in recent years. Whereas informed consent was previously widely thought of in terms of patients agreeing to the one course of action recommended by their healthcare professionals, it is now increasingly thought of in terms of patients understanding what the different possible courses of action are before agreeing to one. This latter understanding can accommodate a variety of different patterns of interaction between healthcare professionals and patients in the process of deciding on a course of action.

It is increasingly accepted that patients should be enabled, and possibly encouraged, to play more active roles in the process of deciding about their health care than they have in the past (13). However, the desirability, feasibility and implications of different models of interaction between healthcare professionals and patients in the decision making process, of different approaches to decision making on the part of patients, and of different ways of supporting patient participation in decision making are as yet poorly understood. (14;15). The relationship between the quality of interaction between health care professionals and patients and the quality of decision making is contested.

Decision making about participation in trials requires patients to consider both which interventions may be appropriate for them and whether or not they are willing to be allocated to receive one of them under trial conditions. The decision may be complicated by the differential availability of particular interventions within and outwith the trial.

There is now some consensus about the basic types of information that people should be given to help them choose between interventions (16), and there is some evidence that decision aids for people choosing between treatment options have

beneficial effects (17). However, there is no clear consensus about what kinds of decision support should be given to help people choose between trial entry or not. It is increasingly recognised that there may be a need to structure information in a way that facilitates comparison of options; to help people to clarify their personal values and preferences and apply these to information; and to provide emotional support to people facing difficult decision (18).

Being asked to participate versus actively seeking to participate in a trial

There are likely to be key differences between the information needs of people who are being actively approached to participate in a particular trial and people who might use a centralised resource. The trial information leaflets given directly to potential participants assume a certain amount of pre-selection by the health professional (for example, the patient will have been judged eligible for the trial, *and* the health professional would like that patient to enter the trial), whereas a central information resource is likely to be aimed at enabling people to decide for themselves whether or not they wish to participate. It is important that these distinctions be considered. It is likely that a centralised database of information about ongoing trials will need to include more information, presented with a different emphasis, to information materials being given proactively to people who are being invited to participate in a particular trial.

2. METHODS

We sought information and opinions about the kinds of information that should be included in a centralised information resource for potential trial participants, the way information should be provided and the issues that might arise, from the following sources:

- published academic literature;
- lay media;
- interviews and focus groups; and
- e-mail discussion.

2.1 Literature review and analysis of lay media

Review of published academic literature

Our brief literature review focussed on three main areas; a) the type of information that should be provided to potential trial participants; b) how information should be provided to ensure fully informed consent, and c) the factors affecting people's decisions about entry into RCTs.

Due to the limited timescale of this scoping exercise, after re-familiarising ourselves with the key debates about informed consent and decision making about participation in RCTs, we focused our attention on guidance and assessment checklists relating to the provision of information to potential trial participants.

Review of guidance documentation for trialists

We analysed four relevant and commonly used guidance documents for researchers. Our analysis focussed on two main areas; a) what information should be provided to potential trial participants, and b) how the information should be provided. The four documents were:

1. MREC guidelines - Guidelines for researchers; patient information and consent form. (guidelines which most researchers have to follow when designing patient information leaflets, in order to receive ethics approval for research).
2. ICH GCP guidelines - The ICH Harmonised Tripartite Guideline for Good Clinical Practice. (This guideline was developed by an ICH Expert Working Group and was subject to consultation in accordance with the ICH process. This GCP guideline is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects).
3. MRC GCP guidelines - The Medical Research Council Good Clinical Practice guidelines in clinical trials (aimed at guiding researchers towards good practice in clinical trials).
4. Research Governance - Research Governance Framework for Health and Social Care (aimed at guiding research carried out within the NHS).

The guidelines are presented in Appendix 1. We checked what elements of information about trials these documents recommended or required to be given to potential trial participants (see Appendix 2). For the latter three, we focused on the sections pertaining to the provision of information to potential trial participants.

Review of available checklists for appraisal of research

During formal interviews with researchers and consumer representatives, four existing guidelines for self-appraisal of research were brought to our attention.

Two of the guidelines were aimed at peer review or ethics committee use:

1. 'A checklist of questions to ask when evaluating proposed research during pregnancy and following childbirth' prepared by the Standing Joint Committee of the British Paediatric Association and the Royal College of Obstetricians and Gynaecologists. It is aimed at advising 'researchers, members of ethics committees and others'.
2. National Breast Cancer Coalition (NBCC) Clinical Trials Project Research Partnership: Criteria for Trial Evaluation prepared by the NBCC. This outlines the principles by which NBCC evaluates research and is aimed collaborating research organisations.

and, two were aimed at use by potential participants:

3. 'Taking part in research studies: What questions should I ask?' available in English and Spanish on the CDC website (www.cdc.gov) and as a link from the NiH website. The guide is also available in a written format and is aimed at HIV/AIDS patients, their family and other interested community members.
4. 'Medical Research and You' prepared by Consumers for Ethics in Research (CERES). It is available in English and CERES are currently undertaking a project to make the leaflet available in several other languages. This guide is aimed at anyone approached about participating in clinical research.

The checklists are presented in Appendix 3. Again we checked which aspects of trials the checklists covered (see Appendix 4).

Media analysis

Transcripts of three TV and radio programmes that focussed on participation in clinical trials were analysed:

1. A Matter of Consent, Spotlight BBC News, 13 February 2001
2. Case Notes, BBC Radio 4, 28 August 2001
3. Harsh Realities 1, BBC Radio 4, 4 March 2001

A brief media review was carried out by searching on the BBC News and The Times Archive websites using 'informed consent' as the search term.

2.2 Individual interviews and focus groups

2.2.1 Rationale for sampling

We recognised that different types of people would have different perspectives on information needs and on the appropriate presentation and provision of that information.

Reflecting this, we sought to elicit information from individuals from four specific groups:

- a) people considering participating in a trial – these are the primary 'target audience' for a central information resource about clinical trials.
- b) people who are currently, or have recently been, participants in trials - those will have had the opportunity to reflect on what information would have been useful to them when they were asked to participate.
- c) representatives of national consumer groups - representatives of national consumer groups are usually knowledgeable about the information needs of their members. Some have also been involved in the design and conduct of trials and have thought through the issues that trial participation can raise for people with particular conditions.
- d) researchers involved in the design and conduct of trials – trialists and trial managers have particular insights into the factors that determine the quality of a trial, and on the feasibility of contributing information about a trial to a centralised resource.

People considering participating in a trial

People considering participating in a trial were identified through national consumer networks. In particular, the National Association for the Relief of Paget's Disease provided names of volunteer individuals who were considering participating in clinical trials and who were willing to participate in this study.

Current participants in clinical trials

We had originally planned to involve current participants in the ongoing MRC randomised trial of calcium and vitamin D for hip fracture prevention; however, due to delays in receiving ethics approval to approach and interview these participants (see below) this was not possible within the time frame of the scoping exercise.

However, over the course of the scoping exercise, we were invited to attend three national meetings involving consumer groups. Specifically these were the:

- National Association for the Relief of Paget's Disease annual patients day;
- MRC 'OE02 trial' consumers day (OE02 is a randomised trial of surgery with/without pre-operative chemotherapy for the treatment of cancer of the oesophagus); and the
- National Perinatal Trials Unit consumers day.

These meetings involved both consumers and people who had been actively involved in trials and clinical research. We listened carefully to the views of these 'real' trial participants as they were expressed in group discussions at these meetings.

In addition, a number of the researchers who we interviewed had also themselves taken part in trials at some time and commented from the perspective of trial participants as well as researchers.

Consumer groups representatives

A purposively selected sample of representatives of consumer groups/organisations was identified for interview. The sample included organisations with an explicit interest in trials and condition-specific groups.

In addition, the views of a number of other consumer groups were elicited during the group discussions at the consumer days referred to above.

Researchers involved in trial design

A purposively selected sample of researchers was identified for interview. These included individuals known to the research team to have an interest in this field, and selected members of the UK MRC Trial Managers Network Advisory Group (a national network of trial managers working on Medical Research Council trials).

2.2.2 Ethics committee approval

Advice was sought on whether ethics committee approval was required for this study. Each of the above samples was considered separately. We were advised that ethics approval was not required for the interviewing of individuals considering taking part in a trial (as all were volunteers identified through consumer groups), for representatives of consumer groups, or for researchers involved in the design of trials. Ethics approval was, however, required to identify and contact current trial participants – this was duly sought from Grampian Research Ethics Committee. Despite submitting our request for ethics approval in time for the November 2001 meeting of the committee, and responding to their requests for clarification of a number of points by 10 January 2002, final approval was not received until 12 February 2002. We were, therefore, unable to interview current trial participants as planned within the timeframe of the scoping exercise.

2.2.3 Recruitment

For potential trial participants, a letter was sent out inviting them to participate in the study, together with an information leaflet describing our research (see Appendix 5). A researcher then telephoned those who indicated they were interested in taking part, to discuss the study further. If the person was still interested, formal consent was obtained and an appropriate time arranged for interview (either face-to-face or by telephone).

For consumer representatives and researchers, initial contact was made either by letter, telephone or email. For those who expressed an interest in the study, an appropriate time was then arranged for interview.

2.2.4 The interview process

Topic guides were used to support semi-structured interviews (Appendix 6). The nature of the interview questions varied slightly according to the type of participant group, but in general, opinions were sought on:

- what information they or others would want/need before deciding whether to join a trial;
- what they might do with that information; and
- how they had or would like to access that information in the future.

In addition, all participants were asked to consider the feasibility and appropriateness of three different forms of information provision: a) the provision of 'star-rated' information on RCT quality; b) the provision of information, without such ratings, or c) the provision of information together with ratings. For most interviews we used three basic vignettes (see Appendix 7) to stimulate discussion about the desirability and feasibility of developing and using a 'star-rating' system to describe the quality of ongoing clinical trials.

Researchers and consumer representatives involved in the design of trials were also asked about what elements constitute a quality trial and about the feasibility of providing a centralised information resource for ongoing clinical trials.

2.2.5 Analysis of data from interviews and group discussions

Most interviews were audio-taped and transcribed in full. If audio-recording was not possible, detailed notes were taken by members of the research team. Interview transcripts and discussion notes were analysed in the same way.

Our analysis of this data was pragmatic due to the short timescale and limited resources available. For data obtained before mid-January 2002, we annotated the transcripts, notes and e-mails and summarised the key points onto charts under

headings reflecting the key issues of interest. The headings were: information needed or not needed to inform decisions about trial participation; other factors affecting or important to trial participation; ways in which information might be used; information presentation formats; models/systems of information provision; media and routes of access; practical issues relating to the development or provision of a centralised resource; and 'other points' that were thought relevant to the report but that did not fit under the chart headings. The information summarised in the charts was used as the basis for drafting the report.

For data collected after mid-January 2002, we added information to the draft report direct from interview transcripts, notes or e-mail as necessary. During the final weeks of the project, in order to check that no key points had been omitted, we divided the transcripts, notes and e-mails among the four team members, allocating data to people who had not gathered it. We all then read our allocated transcripts and notes against the draft of the report and contributed edits accordingly.

2.3 e-mail discussion

To allow wider input to the research, postings about the scoping exercise were placed on the Cochrane Consumers Network and the MRC Consumer Liaison Group e-discussion lists. Each posting encouraged list members to contribute by volunteering responses to four short open questions about information needs and provision (see Appendix 8). Email contributions to the project were analysed in the same way as interview data (see section 2.2.5 above).

2.4 Presentation of findings

We decided that, rather than presenting the literature review, the interviews and the e-mail discussions separately, we would discuss all our 'intelligence' about specific topic areas together. We felt that this would help the interpretation of our findings and would indicate where issues raised by participants were supported from multiple sources and/or by the research literature.

3 CONTRIBUTORS

Over the course of the study we interviewed a number of individuals on a one-to-one basis and elicited the views of many others in a focus group or group discussions context. We formally interviewed:

- nine potential trial participants;
- six consumer representatives (mainly, but not exclusively, people from organisations actively thinking about trial participation);
- nine researchers (including trial principal investigators, trial managers and a research nurse); and
- one pharmaceutical/medical devices industry representative.

Consumer organisations/groups whose representatives were formally interviewed on a one-to-one basis included:

- Consumers for Ethics in Research (CERES);
- INCONTACT;
- National Association for the Relief of Paget's Disease (NARPD);
- National Childbirth Trust (NCT);
- Terence Higgins Trust; and
- an independent consumer advocate.

In addition, the views of 24 further consumer or patient advocate groups were elicited at the national consumer days attended. For a full list of the consumer organisations represented see Appendix 9. A number of those consumer representatives had personal experience of involvement in clinical research and trials, as did some of the researchers, and these formed the basis of the views of 'actual' trial participants. This included one individual who had refused participation in a trial.

A further nine responses from consumer representatives were received via the e-mail discussion correspondence.

4. WHAT INFORMATION ELEMENTS DO POTENTIAL TRIAL PARTICIPANTS NEED AND WHY

In this section we consider what information elements were considered important for inclusion in a centralised information resource about ongoing trials. This was intended to help people to identify and make decisions about entering a trial. We have organised this section under headings that relate primarily to the reasons people want information. Within each section we consider: a) who thinks this is important; b) why they think the information is important and c) issues related to the inclusion of this information within a centralised resource.

In summarising information gathered from interviews, discussions and e-mail correspondence below, we have used some verbal quantifiers (a ‘few’, a ‘majority’ etc.) to convey our impression of the extent to which views were widely and strongly held. However, we would like to stress that we did not set out to and cannot fairly quantify the distribution of views across particular groups.

4.1 The quality of a trial

“a reassurance that the trial is kosher”

Not surprisingly, there was a strong consensus view that people need to know that any trial they consider participating in is of good quality. ‘Quality’ is a complex concept, and several key aspects of quality were emphasised by respondents. These included the importance of the research question being asked and the nature of the difference that the trial could make; the scientific or methodological quality of the trial and the robustness of the knowledge it would generate; and the ethical probity and acceptability of the trial. Although the three aspects are related, we discuss them separately below.

a) The importance of the trial

Rationale and information elements

There was a strong consensus about the importance of explaining to potential participants why a trial was thought necessary, what questions it would answer and

what kinds of benefit it might bring to whom. The basic argument was that if people are being asked to participate in a trial, they should be told whose, and which, ends it was serving.

Researchers and consumer advocates were particularly aware that trials varied in their potential to benefit health service users. Several expressed concern that some commercially funded trials of very similar drugs were unlikely to inform substantial progress in terms of treatments, and felt this should be made clear to potential participants.

The types of information that might be used to communicate the general purpose and likely benefits of the knowledge generated by the trial include:

- A statement of the research question being addressed (information about the health problem focussed on, interventions being compared, and the outcomes being assessed). The nature of the interventions being compared and the outcomes being assessed reflect to a large extent the purpose of the trial.
- A description of what is already known about the effects of the treatment which is the focus of the trial (or preferably of the treatments being compared) and an explanation of what knowledge the trial in question could add.
- An explanation of how the trial findings might inform or improve health care (for example, by helping the health service make informed decisions about whether a new drug should be given a license for routine use).
- A statement of the plans for reporting the findings of the trial.
- Information about who has funded the trial and the rationale underlying their decision to invest money in it.
- Details of organisations that have endorsed or offered support for the trial and information about the rationales underlying their decisions to do so. (For example, it was suggested that people should be told if a trial addressed a research question identified as a priority by a consumer organisation).
- Information about the costs of the interventions and other factors that might affect their uptake within the health service (whether or not the trial included a cost-effectiveness analysis was also mentioned in this regard).

Issues of information provision

For trials funded via the public or voluntary sector, trialists are already required by funding bodies to provide a summary of the available research evidence and an explanation of what information a proposed trial would yield and how it would benefit the NHS and users of its services. However, it was suggested that this information is often not provided in information materials for participants – and it is striking how little of the guidance to researchers about providing information to potential trial participants mentions this (see Appendix 2).

Several respondents expressed uncertainties about how much detail should be provided about what is, and is not, known from previous research. Although there is a general consensus that truth-telling and respect for autonomy should take precedence over paternalistic concerns to avoid upsetting people, there are nonetheless some outstanding concerns about what constitutes full or ‘adequate’ disclosure of the uncertainty of treatment or effectiveness, and the possible effects of this. The lack of consensus about whether and how to present uncertain or tentative findings are in part due to limited understanding of the consequences of providing this information in different ways.

Although it was not discussed during interviews, which focused on randomised controlled trials, we also suggest that if the centralised information resource was to include information about early phase clinical trials, the different nature and status of these should be clearly pointed out.

The difficulty of assessing or comparing the importance of the research questions addressed, and the likely contribution of different trials was noted. The differing amounts of pre-existing knowledge relating to particular conditions and interventions means that the types of knowledge gaps to be filled are quite varied. It might, however, be possible to develop basic categories to distinguish between the state of knowledge relating to a particular condition/intervention and then to distinguish between the type of knowledge contribution that a trial was likely to contribute.

Differences in public perceptions about the effectiveness of currently available treatments might also affect perceptions of the importance of trials of new

interventions and people's willingness to participate in trials. The history of trials of treatments for HIV and AIDS has highlighted how people may be more willing to participate in trials of new interventions if they perceive substantial limitations in the ones that are currently available (see box).

"So what we've seen with HIV is that recruitment to trials up to 1996 was relatively easy, because among other things being in a trial gave you access to experimental drugs in the absence of other effective treatments. Much has changed since the arrival of combination therapy... a substantial number of people with HIV are maintaining their health to a better standard than they could ever have expected.... So the number of people for whom treatment is failing has become much smaller, and within those circumstances it is more difficult to persuade people to take part in trials which may seem to have no immediate benefit to them."

b) The scientific or methodological quality of a trial

'I'd want to know that it wasn't some little tin pot something'

Rationale and information elements

Researchers and consumer advocates in particular emphasised that people should be able to find out whether any trial they considered participating in was going to be 'done properly' in a scientific sense and produce knowledge that could be relied upon. However, they recognised that relatively few people would be able to judge this for themselves on the basis of a description of the trial study design and methods. A number of organisations are beginning to address this. CERES, for example, indicated that they were exploring setting up a central support group for

people involved in research. Part of the remit of this support group was likely to include independent quality assessment of trials.

The types of information that might serve as indicators of scientific quality include:

- Features of trial design and methods, for example (†):
 - how many people will be allocated to each different trial arm;
 - how will the randomisation be done; and
 - how will the data be analysed.
- Information about the scientific quality assurance processes that the trial has been through eg has the trial been through an independent and rigorous peer review process?
- Information about the track record and reputation of the group running the trial.

While it was recognised that the source of funding was not a reliable indicator of the scientific quality of a trial, there were concerns about the ‘independence’ of the people doing the trial. Several respondents suggested it would be helpful to know about the working relationships between research funders and the people running the trial. They wanted to be reassured that trials were conducted, evaluated and reported independently (i.e. that the findings themselves were not going to be distorted by vested interests).

Issues of information provision

Respondents recognised that the question of how much detail about trial design and methods should be provided to potential trial participants is a difficult one. There are tensions between providing full information and facilitating understanding because the complexities of trial design are often not readily understood.

† It would be inappropriate to try to produce a comprehensive list of indicators of the methodological quality of trials on the basis of information gathered during this project. We have listed the indicators specifically mentioned as important by respondents, but note that several people referred to ‘the standard stuff’ about methodological quality. A substantial amount of work relating to the scientific quality of trials has been carried out

The tension between the published guidance and legislation (to which trialists have to adhere when developing patient information materials) and the wish of individuals to have access to varying degrees of information (a more tailored information provision) was also raised in this context. The current regulatory guidance is generally interpreted as requiring trialists always to provide people with 'full' information whether or not the patients wish to receive it. In addition, the information elements recommended by the guidelines for inclusion are not directly comparable to those raised by our interviewees (Appendix 2). A possible solution might be for amendments to be made to existing guidelines and legislation which, instead of requiring researchers to pursue full disclosure of information to potential trial participants, rather requires researchers to provide a mechanism for tailored information.

Several respondents also noted that trialists might want to withhold some details about the study design and methods from participants if revelation of those details might threaten the robustness of the trial findings. For example, in trials of psychosocial interventions and trials which assess psychological or psychosocial outcomes it is important to avoid shaping people's expectations of the interventions being tested or otherwise moderating their outcomes.

A good assessment of the scientific merits of trials in the context of a rigorous peer review process should ensure the scientific quality of trials, but there were some concerns about the variable quality of peer assessments and peer review processes, and whether a simple statement that a trial protocol had been peer reviewed could constitute 'adequate' information, or provide adequate reassurance, about the scientific quality of a trial.

c) The ethical probity and 'governance' of a trial

Rationale and information items

Not surprisingly, respondents stressed the importance of providing information about the ways in which trial participants' interests would be safeguarded.

As with the general issues of scientific quality, it was recognised that information relating to ethical considerations and research governance could take the form of

detailed descriptions of specific features of a trial, information about the ethical standing of the people carrying out the trial, or information about the ethical quality assurance processes that were in place. The types of information suggested included:

- Information about specific features of a trial:
 - What are the risks directly associated with interventions in any of the trial arms?
 - Is care in all intervention arms at least as good as 'usual care' outside the trial?
 - Has the safety of the interventions being tested been maximised?
 - Has the safety of any follow-up measurement procedures been maximised?
 - Are potential participants appropriately informed about any risks associated with the interventions and follow-up procedures?
 - Will data be stored safely?
 - Will participants' details be handled confidentially?
- Information about the people/organisations involved and quality assurance arrangements:
 - Who is running the trial, and which clinicians and clinical centres are involved?
 - Has the trial been assessed and approved by an appropriate research ethics committee?
 - Has the trial been assessed and considered acceptable by an appropriate consumer organisation?
 - Is there a data and safety monitoring committee for the trial? Who is on it, and when does it meet?
 - What other safeguards are in place to protect the wellbeing of trial participants?
 - What are the rules for stopping the trial?
 - Have arrangements been made for looking after participants if things go wrong? For example, has insurance cover been arranged?
 - Who should people contact if they had any concerns about the ethical probity of the trial? Suggested contacts included:

- the person in the relevant organisation (hospital, university, etc) responsible for research governance;
- the relevant ethics committee(s); and
- the data monitoring committee(s).

Issues of information provision

A number of respondents commented on the role of trust in a person's decision to participate in a clinical trial. People may tend to 'trust' that a trial done by a particular doctor, hospital or institution will be a good one. Some individuals and organisations put a lot of effort into maintaining good public relations and reputations.

A good assessment of the ethical issues raised by trials in the context of a rigorous ethical approval process, should ensure the ethical quality of trials (especially if sound research governance arrangements are in place), but there were some concerns about the variable quality of ethical assessments and the ethics review processes.

Again there were differences of opinion about how much detail people should be given. There was recognition that people's preferences for levels of detail with regard to how their interest would be safeguarded would vary.

"I don't want all the practical logistics. I just want to know that things will be confidential, that records will be stored safely, that my name won't appear.

That kind of stuff."

4.2 The interventions being compared

As expected, there was a consensus that potential trial participants needed to know about the 'new' treatment (it was widely assumed that there would be a 'new' treatment in every trial), its potential risks, how it compares with the treatments given in the other trial arms *and* how it compares with the current standard treatment.

As one respondent suggested, most people thought that potential trial participants should be given “all the information that’s relevant to give informed consent” to any of the interventions they might receive in the trial. Although there was not a clear consensus over which information is relevant to give informed consent to particular treatments, in general it was accepted that people should be told about:

- the processes involved in the interventions, including where and how they are delivered;
- how the interventions are meant/thought to work and what benefits it is hoped they will bring; and
- what is already known about their effects, both positive and negative.

The availability of the interventions that were being compared outwith the trial was also mentioned as important by several respondents.

Issues for information provision

The question of how much detail should be made available emerged again in relation to information about the interventions being tested. There were differences of opinion about how much people want and need, and what the effects of giving different amounts of information and in different ways would be.

The most contested area was information about very low-probability risks of interventions. There was a clear view that “you can sometimes go over the top listing every possible toxicity”, and that some of the detailed information that pharmaceutical companies and trialists feel a need to include “to protect their own backs” was not particularly helpful to potential participants, at least not in some formats.

There was a clear recognition that better ways needed to be found to communicate about uncertainties and probabilities, and that the effects of different ways of presenting information needed to be better understood. The types of risks associated with interventions and with their underlying conditions also varies considerably. For example, the death rates associated with any intervention given as treatment for people who have had a heart attack would probably be much higher

than the death rates associated with interventions given to relieve the pain of women in labour. This might make it difficult to make fair comparisons between trials in relation to these issues.

There were also some suggestions that details about interventions might need to be withheld from participants and the public in order to preserve the 'blinding' of the trial and hence its validity. One respondent gave a hypothetical example of a trial in which one of the interventions being compared affected urine colour but was not harmful. If the fact that the intervention affected urine colour was mentioned in the trial literature, it would enable participants to identify which intervention they had been allocated to and hence potentially introduce bias into the trial. In situations like this there is a tension between maintaining methodological rigour and allaying subsequent concerns of patients.

It was further recognised that some people (usually those who are extremely well informed about their condition and its treatment) may seek trial participation in order to have a chance of obtaining a particular treatment. We cannot debate all the ethical issues that are associated with the provision or withholding of unevaluated treatments outwith a trial here but comment that the consensus among our respondents seemed to be that people should be told about the wider availability of interventions whatever the situation was.

4.3 The implications of the trial for participants

"Basic practical things. What exactly will I be asked to do?

When will I be asked to do this? And for how long?"

Again there was a strong consensus about the importance of informing people of the implications that participation in a trial would have for them. The main types of information required related to where, and when, the trial interventions would be given and trial outcomes assessed. Specific points which respondents felt would be necessary to provide included:

- any extra visits associated with the trial (eg. to receive interventions or to be assessed for follow up);
- any extra tests or investigations associated with the trial (again as part of the intervention package or as part of the follow up assessment);
- how long individuals will be followed up for; and
- how long the trial will run for.

Several respondents highlighted the need for specific information to be available describing the consequences of agreeing to participate on their continued involvement:

- If I say yes to participate now, can I withdraw later? If so, up to what point? How can I do this?
- If I say no to participate now, can I join the trial later? If so, up to what point? How can I do this?

Other aspects that respondents raised were that potential participants should be told about:

- whether or how they could obtain, or would be given access to, data about their own outcomes;
- whether or how they could obtain, or would be given access to, information about the findings of the trial; and
- plans to communicate with participants if a trial was stopped early for any reason.

It was also suggested that, if possible, it would be good to give potential participants an indication of the extent to which participants would be made to feel as though they were valued for their contribution to a particular trial.

Issues for information provision

Several factors make it particularly difficult to provide standardised assessments of the quality of trials in terms of the implications for participants. There is no clear and simple association between length of follow up, number of outcome assessments etc. and trial quality. For example, some conditions and interventions will require longer term follow up than others. A trial investigating pharmaceutical treatments for

an acute minor illness such as a cold would probably require a shorter follow up period to count as a 'good' trial of those treatments than a trial investigating pharmaceutical or surgical treatments for a chronic health problem.

Also, the majority of respondents acknowledged that for most people information needs would be context-specific. Needs were likely to vary across clinical and environmental factors (such as health condition, type and state of development of treatments, cultural groups and time), and individual factors (such as gender, age and educational level). For example, while some people would find extra clinic visits a burden (perhaps because they were difficult to fit in with work patterns, or required a tiring, expensive journey), others would welcome the additional clinical monitoring of their condition and extra contact with health professionals that these would bring.

There was some uncertainty about whether information about the availability of support costs, for example to pay for people to travel to any additional clinic visits that were part of the trial, should be required. While this information could probably be included with little problem in an information package associated with a particular trial, if all trials were required to state whether or not such support costs were available it would be likely that the majority would say no. This might look 'depressing', might put people off participating, but might also spur future trials to make more effort to ensure participants did not end up out of pocket.

4.4 The option to talk to someone about the trial

Several respondents from all categories mentioned that potential trial participants might benefit from the option to talk to someone before deciding whether or not to participate in a trial, and possibly also during the trial. The case was regularly made that two-way interaction was key to understanding information, as any misconceptions could be corrected and personal concerns could be addressed. The options suggested were:

- having a chance to speak with a member of the trial team (preferably someone who is not related directly to a person's normal care) - someone who can explain things like randomisation;

- being given an option to be able to contact a knowledgeable person for further information and explanation if required;
- having a chance to talk to an independent person (i.e. someone not associated with the trial, for example a GP if invited to participate in a trial from secondary care);
- having a chance to speak to a patient/consumer ‘advocate’ who is linked to, and familiar with, the trial but is ‘outside’ or somehow independent of it;
- having access to other support outside of the research team if required; and
- having contact details, so know whom to contact if concerned about anything while participating in the trial.

If information about a trial were publicly available in a centralised resource, people considering entering a trial would be likely to need:

- contact details for initial enquiries about the specific trial and (possibly subsequently) local recruiting centres/clinicians; and possibly
- an information helpline staffed by people who could offer general information, answer general questions about trials, and help explain information provided about specific trials.

If, however, the capacity of trialists or trial centres to handle unsolicited enquiries was limited, they might be reluctant to have their contact details ‘advertised’ in the context of an information resource that promised help to people identify trials in which they might participate.

5. FACILITATING UNDERSTANDING AND APPRAISAL OF INFORMATION

5.1 Lack of awareness of randomised controlled trials

If a central information resource about ongoing clinical trials is intended to help people make informed decisions about whether or not to participate in particular trials, it should obviously provide information about those trials in a way that is easy to understand.

It was widely acknowledged, however, that there is a general lack of awareness and knowledge of clinical trials by the general public. Particular issues that were raised included:

- People often don't understand that two treatments are being compared and that they might get allocated 'routine' care within a trial. This can lead to people being disappointed if they are allocated to the routine care group, which may affect the outcomes.
- People have concerns about the concept and mechanism of randomisation – they find it difficult to accept that their allocation to treatment will be completely at random.
- The word 'trial' has various connotations for different people. Some people link this with the concept of 'experimentation' and with being a 'guinea pig'.

For the benefits of a central resource to be maximised, it was recognised that general levels of awareness and understanding would need to be increased.

Suggestions of how this might be achieved included:

- including the role of clinical trials in school curricula;
- including sections on clinical trials in healthcare booklets provided to the general public eg the 'Ready Steady Baby' book provided to all pregnant women;
- supporting media campaigns by recognised organisations (this might include television documentaries); and
- seeking to place articles about clinical trials in health magazines.

5.2 Facilitating information within a centralised information resource

With regard to facilitating understanding within a central information resource, we explored two basic options to help people evaluate that information:

- a star/quality rating scheme; and
- a guide to help people appraise particular trials for themselves.

5.2.1 A star/quality rating scheme

For illustrative purposes and to stimulate discussion, we showed most of the people we interviewed three examples of extracts of information about a hypothetical trial (see Appendix 7). For the same subset of information elements, one example

contained descriptive information only, one contained star ratings only, and one contained a combination of descriptive information and star ratings.

The star/quality ratings option received some support primarily because of its simplicity. However, it raised a number of concerns, some of which were particularly strongly felt. The concerns raised and suggestions made included:

- A fundamental question about how valid and meaningful a rating system could be.

“I’m not a fan of ratings, I have to say, because they quantify something that is actually very qualitative”

- A concern that a system of star/quality rating that is not accompanied by descriptive information would be “too cryptic” and not informative enough. This is probably particularly true if ratings are applied to each aspect of a trial about which information might be provided, as the reader would have to familiarise themselves with the criteria associated with each information element.
- A concern about the fairness of applying a standard rating system. It would be difficult to provide comparable ‘ratings’ for some important elements of trial quality that were meaningful across the different kinds of health condition and interventions that trials cover.
- A concern about the appropriateness of providing ‘generally applicable’ ratings for aspects of trials that would be highly preference sensitive. For some features of a trial there might be wide differences of opinion across potential participants about how a particular element of information, or ‘fact’, should be valued. (for example, for some people additional clinic visits may be a burden, but for others a bonus).
- The question of *who* would do the rating and how reliable this would be – even given a set of rubrics. If ratings were used, the system for applying them would need to be, and be recognised to be, independent. It was generally recognised that the question of who would apply the ratings was a ‘big’ issue. There is a need for an acceptable set of standard rubrics, but these would have to be applied to trials of very different types. The suggestion that trials could be rated by a ‘combination’ of consumers, trialists and perhaps experts in a particular

disease was offered to ensure that multiple perspectives were covered, but would mean that different groups of people would have to rate different trials – again raising questions about standardisation.

- A concern that a system that allows a trial or particular aspect of a trial to be rated either one, two or three star might not allow adequate differentiation between trials of different quality. A rating scheme with a greater number of categories (say five rather than three star options) could be more informative. However, the use of a larger number of assessment categories also increases the demands made on raters to differentiate precisely.
- An overall assessment of the ‘key things’ of a trial might be preferable to a series of assessments on separate aspects of the trial. The main candidates for ‘the key things’ were the basic ‘soundness’ of a trial and the ‘safety’ of participants within it. Despite their possible limitations, the most obvious checks on these were that the trial:
 - had been through an independent peer review process (ie a check on scientific quality); and
 - had been assessed and approved by an independent ethics committee (ie a check on ethical probity).
- A concern that particular ratings were likely to be contested by trial sponsors and trialists, and that this could create a lot of ‘hassle’ and work for the resource producers.

“I think that you've got to be really convinced that the simplicity [given by the star ratings] is worth your while... You've got to be convinced it's rigorous enough to be able to write back to irritated principal investigators...”

5.2.2 A guide to help people appraise particular trials for themselves

There was general enthusiasm for the suggestion that, as part of the central resource package, there would be a ‘guide’ to help people appraise key elements of trials for themselves.

“Giving people the questions to ask. Because if you don't know what questions to ask, you're not going to be able to assess it, are you?”

The one note of concern about this, raised by a research nurse (who was apparently thinking that it would be given to people who were being approached and invited to participate in a trial) was that this might place an additional burden on people, or give them extra cause to worry.

It was suggested that some existing checklists developed for peer reviewers, ethics committees and consumer appraisers could be modified for more general public use. Currently, however, there is little consistency across these checklists, some of which are very comprehensive while others are comparatively narrow in their range of suggested information (see Appendix 4).

6. A CENTRAL INFORMATION RESOURCE FOR CLINICAL TRIALS

6.1 Potential advantages and disadvantages

There was widespread support for the concept of a centralised information resource for clinical trials. Several potential advantages and disadvantages of such a system were put forward. These were that:

- It could provide standardised, semi-independent information about trials to people who have been invited to participate and want to find out more. Imposing a standardised information structure could, however, be disadvantageous to some trials especially those for which certain aspects of the proposed structure are of little importance.
- It could allow people who have not been invited to participate in a trial, but would like to, to identify any ongoing trials for which they might be eligible.
- It could allow people who are participating in trials, but want to find out more, to access information about the trials in which they are participating.
- By providing information in a standardised way, it may present a fairer reflection of ‘good’ trials whose current information materials are of poor quality (ie ‘good’ trials whose current information materials would otherwise create a poor impression).

- It could be used to make ‘available’ information that might be wanted by some people, but is not thought essential for all potential participants (this might include ‘optional extra’ details that some people might want but that might constitute information overload for most people).
- It would make it much easier for people to find out about trials that their family members or friends have been invited to participate in or are participating in. It was recognised, however, that having a central resource would make it much easier for anyone to find out about trials that a person has been invited to participate in or is participating in. Knowledge that someone is eligible to participate in a particular trial (which could easily be found out, for example, by spotting a sticker on the person’s hospital notes or a piece of trial correspondence) could reveal information about personal health status or health care experiences.

6.2 Key features

Standardised structure for the reporting of trial information

It was felt that the information within the centralised resource should be reported in a standardised manner. However, the system should be flexible enough to allow optional links to other resources, for example links to the individual trial sites.

Up-to-date information

It was widely acknowledged that the information needs for people do not stop at the ‘decision-to-enter’ stage. As individuals progress within a trial, and as their understanding of the process increases, it is highly likely that they will wish continued information. It is also a central tenet of informed consent that a patient has the right to withdraw at any stage. It is, therefore, essential that up-to-date information is available for these individuals if, and/or, when they wish to re-evaluate their participation in the research. This would also allow people who had initially declined to participate in a trial to re-evaluate that decision at any time.

A general information section

There was widespread support for the provision of a general information section within the centralised resource. This section could include:

- general information explaining the purpose and key features of clinical trials;
- a glossary of commonly used terms in research, especially those related to clinical trials methodology;
- links to organisations who would be willing to provide generic support and information about clinical trials; and
- a 'guide' to help people appraise elements of the trial for themselves.

A structured or layered database

Respondents recognised that the question of how detailed the information provided to potential trial participants should be is a difficult one. There are tensions between providing full information and facilitating understanding. The provision of layered or structured information within the central resource was seen as desirable in this respect. This would allow people to choose what kinds of information they would like, in as much detail as they would like. The initial information presented could be a basic description of the trial, with supplementary information available if people want to access it - for example, links to the actual trial information leaflet, the protocol summary etc.

A searchable database

A number of respondents expressed the desire to have a fairly sophisticated search facility within the resource. People would like to be able to enter their personal details (eg health condition, age, gender, geographical location etc), and ask the system to filter out all the trials directly relevant to their health condition and to their wider personal profile.

Respondents also felt that people should be able to access relevant information quickly and easily, otherwise they would not use the system. For example, a contributor to one of the radio programmes outlined the frustration she experienced when trying to identify UK trials on multiple sclerosis from the Internet. Although she eventually found 50 trials, she felt there was no easy way to check which of these were relevant.

"I feel frustrated. I don't feel like I've learnt anything new, there has been some useful information about what clinical trials are which we've come across more by accident than design, but I would have no more idea about how to get on a clinical trial or what clinical trial to get on than I did before I started. I think what you should be able to do is put in your interest, your particular type of MS [multiple sclerosis], and see if you personally fit any of the profiles of trials and then find out information. I think that would be a much more interesting and more useful way of doing it for everybody."

Presentational issues

It was widely acknowledged that the packaging of information is very important. Whilst there was recognition that there is a tension between the needs of trialists to ensure that information is provided in sufficient detail to allow true informed consent (indeed this obligation is placed on them by ethics committees who grant approval), and ensuring understanding without overload, there was a clear consensus across all groups that information presented should be in simple language with the use of scientific terms kept to a minimum:

"I think it has to be written very carefully. And that any scientific terms that are used are thoroughly explained, if they are not self-evident.

**There is this tendency
sometimes to baffle people with science."**

Linked with this view was also the perception also that information presented should be short in nature. The general view expressed was that succinct information would aid the decision process, and that a trial should be able to be summarised clearly on one or two sheets of paper. Some expressed the view that if the trialists could not summarise the information succinctly, this might be an indicator that the rest of the trial was equally unfocused.

There was also widespread support for the use of a variety of media to present information. Many respondents felt that greater use should be made of 'visual communication skills'. For some interventions it was recognised that diagrams or video-clips could be very useful to help people understand the processes involved; for example in a trial of different knee replacements, diagrams could be used to show the different types of prostheses being compared. Consideration should be given to accommodate visual aids within the central information resource for clinical trials. However, this would not be appropriate for every trial.

7. POTENTIAL MODELS OF PROVISION

When considering potential models of provision of a central resource for information on clinical trials, two main aspects need to be considered. Firstly, consideration must be given to the potential platform or host for such a resource, and secondly consideration must be given to the best ways of accessing the resource.

7.1 Potential platform – *metaRegister*

Currently there are a number of registers of ongoing trials available, primarily accessed via the Internet. These may contain some of the elements of information required for a resource for potential participants, but they have not been developed directly from the information patients want. The three main sources which we identified were:

- *metaRegister* (www.controlled-trials.com)
metaRegister (*mRCT*) is a major international database of ongoing randomised controlled trials in all areas of healthcare (it is an amalgamation of trial registers held by public, charitable and commercial sponsors of trials). It is UK-based, and promotes the prospective registration and identification of trials using a unique numbering system, known as the International Standard Randomised Controlled Trial Number (the ISRCTN). The *mRCT* is a free service that allows users to search all participating registers, all of which are asked to submit trial records including specified data items. Currently, these items include aspects such as the trial identifier, trials details (including

disease or condition, trial status, links to patient information materials where available, design features, eligibility criteria and interventions).

- The NiH register (www.clinicaltrials.gov)

The NiH register lists ongoing trials in all areas of healthcare. It is US-based and focussed mainly on trials being conducted in the United States.

Information about their trials are summarised under key headings: purpose, condition, treatment or intervention, further study details, eligibility, location and contact information; and, a link to more detailed information. Within this system you can search by a number of factors eg health condition, trial location, age group and trial funder.

- The HIV/AIDS register (www.aidsmap.com)

The HIV/AIDS trials register, as the name suggests, focuses on trials ongoing within the HIV/AIDS field. It is also structured under key headings: purpose of the study, trial structure, potential side effects, eligibility, further information, trial sites; and, trial status.

Detailed examples of trial descriptions from each of these websites are presented in Appendix 10.

7.2 Potential means of accessing the database

The Internet

There was widespread support for the provision of a searchable register of trials available on the Internet. The Internet is increasingly being used by both professionals and the public alike to both provide and access information. Anecdotal evidence suggests that the public are increasingly turning to the Internet for health information and increasingly taking that information to consultations with health professionals. This trend seems set to continue.

Whilst the Internet was seen as a key outlet for the potential searchable register of trials, almost all respondents acknowledged that access to the internet was not possible or desirable for some people. These results are borne out by the findings of the most recent General Household survey conducted in 1998/9 (19), which highlighted that, although the trend to own a home computer was increasing, only

34% of households currently had access to a home computer. Additional routes of access are, therefore, also required.

NHS Direct/NHS 24

Given the national infrastructures that have recently been put in place across the UK to provide healthcare advice by telephone (by means of NHS Direct in England and Wales, and NHS24 in Scotland), many respondents felt that this might be an appropriate vehicle to access information on ongoing trials. Callers could ideally access the information by phone, and also be able to talk to a trained nurse about clinical queries.

The data from the General Household Survey (referred to above) supports the wide availability of telephone access for the general public - 96% of households have access to a telephone.

Consumer associations

A number of respondents indicated that they would contact their consumer organisation/group if they were looking for ongoing trials in their field. As such, they indicated that it would be helpful if each consumer group could either have access to the entire register or have access to the subset of trials relevant to their condition. A further potential benefit of this method was that people could talk to, or get advice from, the consumer organisation in addition to accessing the trial information.

Other potential outlets

Other potential outlets suggested included access via GP surgeries, hospital clinics and public libraries. Within these different settings, a variety of options for accessing information could be provided, for example: access to the internet register could be made available; searches of the internet register could be undertaken; or printouts/downloads of register entries could be available for direct reading.

7.3 Advertising the register

Respondents suggested that if such a register of trials was to be made publicly available, potential trial participants and healthcare professionals need to be made aware of it. Suggested outlets for advertising included: on television, in health

magazines; and/or in the national press. The register could also be highlighted in GP surgeries, hospital clinics and/or public libraries.

7.4 Suitability of *metaRegister* as a host for the centralised resource

As the *metaRegister* coordinators are UK based (*Consumers in NHS Research* also requested contact with *metaRegister*) we involved them directly in discussions as to the feasibility of providing the types of information and searchable structure our respondents had identified.

Discussions centred around the desirability and technical feasibility of adapting the *metaRegister* of controlled trials (*mRCT*) to fulfil the needs of a proposed central information resource about clinical trials for potential participants. Three main areas were discussed:

- a) proposed content of the resource;
- b) proposed features of the resource; and
- c) access to the resource.

a) Proposed content of the resource

Provision of a general information section

The *mRCT* currently provides a 'frequently-asked-questions' section on their site, and as such, the developers were very supportive of the concept of providing a general information section for potential participants (it was also deemed to be technically feasible).

Addition of extra/supplementary information elements

The *mRCT* acts as a repository for information generated via a number of disparate research registers (currently 23 registers contribute, from four continents). It is each source register, rather than *mRCT*, that seeks and generates individual information elements direct from the trialists - the source registers pass the information on to *mRCT* and are effectively the gatekeepers to the information, although the *mRCT* does recommend an 'essential dataset' for inclusion. If extra items of information are required to make the centralised resource useful to potential trial participants it is,

therefore, likely that the individual source registers will have to be liaised with directly to facilitate this.

The National Research Register (NRR) currently contributes UK records to the *mRCT* (approximately 50% of the records on *mRCT*). It is recommended, therefore, that discussions be initiated with the NRR, in the first instance, to explore further the feasibility of wider information collection. However, should the NRR, or any other register, expand its information base, *mRCT* would be able, in principle, to accommodate it.

It was acknowledged that the *mRCT* might not wish to store centrally all the supplementary information (indeed this might not be technically feasible). However, it could easily provide links to any other site storing supplementary information locally (for example, individual trial websites). In this way, a variety of information including patient information leaflets could be accessed fairly easily.

The possibility of combining increased information provision with an application to receive an ISRCTN was also discussed. Currently, trialists have to provide only minimal information before an ISRCTN is allocated; in particular the information is such that it does not require updating. This minimum data approach is advocated so that as many trials as possible will register (ie the process is as simple as possible). It was felt that the aim of the ISRCTN might be compromised if registration was linked with providing more detailed information about each trial.

b) Proposed features of the resource

Search facility

The *mRCT* currently allows people to search using textword(s) and Boolean operators (eg 'and', 'or'), and the development of more advanced searching is planned. No background coding structure is currently imposed on the source registers, hence more advanced searching is not possible at this time. As such, the system cannot currently recognise, for example, that 'cancer' and 'neoplasm' are synonymous. In principle, the developers of *mRCT* support further development of a more sophisticated search facility. However, it was acknowledged that this would require external financial investment and development time. Collaboration with the

source registers would also be required. An initial model may be to encourage collaboration between *m*RCT and one, or maybe two, source registers (possibly the NRR or the new ABPI register) to explore the feasibility of this further.

Incorporation of visual aids

It was acknowledged that the *m*RCT might not wish, or be able, to support items available in different media centrally. However, as with the supplementary information, it could easily provide links to any other site which stored information in different media. In this way, it was believed that access to video-clips or technical diagrams associated with specific trials would be feasible.

c) Proposed access to a centralised resource

*m*RCT is allowed to host and display the information provided by the individual source registers on the condition that it does not pass the data items to others. As such, active distribution of subsets of the register to specific groups eg consumer organisations would not be feasible.

External access to the *m*RCT via the Internet is free. As such, the best model of access was believed to be via the Internet. For people not able to access the Internet themselves, it was felt that a consumer organisation (or any other agency) could access and download information direct from the *m*RCT on their behalf – effectively acting as a broker.

8. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

- There was widespread support for the concept of a publicly available resource containing information about ongoing clinical trials designed for use by potential participants.
- When considering information about trials, people want to know about the quality of the trials, the interventions being compared and what participation would mean for them personally.

- People prefer to have access to someone to discuss their potential involvement in a particular trial.
- There was widespread support for the provision of a 'guide' to help people self-appraise aspects of a clinical trial.
- People would like to be able to choose which information elements they wanted to see and the level of detail to see them in.
- People would like to be able to search the central resource using a combination of relevant criteria.
- People would like to be able to access the central resource both via the Internet and by other means.
- On an Internet-access version, people would like to be able to transfer or link directly from the central resource to other relevant information sites. For example, they would like to be able to 'click through' to specific trial information sites.
- The gathering of all the information seen as desirable for the centralised resource might be practically difficult.
- A considerable investment would be needed to develop the kind of search engine and interface seen as desirable.

Recommendations

There are a number of clearly desirable features of a centralised information resource for clinical trials. Whilst we accept that the provision of some of these features may be impractical, and that each will have resource implications, we recommend serious consideration of the following:

- Provision of a 'guide' to help people appraise key elements of trials themselves.
- Provision of a kite mark (as an indicator that a trial has passed a minimum quality threshold) to trials for which 'the key things are in place'.
- Provision of a flexible system to allow:
 - people to focus on what information they want, and in what detail they want;
 - people to search the central resource using a combination of relevant criteria;
 - the incorporation of visual aspects such as diagrams or videoclips; and

- links to other relevant information sites eg specific trial sites.
- Provision of a resource not only via the Internet, but also by other means of access such as via NHS Direct/NHS 24 and/or via consumer organisations.
- Initiation of discussions with a primary register of trials (eg the National Research Register) to investigate more fully the feasibility of gathering all the information elements seen as desirable.
- Initiation of discussions with *meta*Register and a primary register of trials (eg the National Research Register) to develop a more sophisticated search engine and interface.

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