NUFFIELD COUNCIL ON BIOETHICS

Consultation Response:

Revision of CIOMS 2002 International Ethical Guidelines for Biomedical Research Involving Human Subjects

Guideline 12: Use of health-related data in research

General comments:

- The comments below draw on the findings of the Nuffield Council on Bioethics report '*The collection, linking and use of data in biomedical research and health care: ethical issues'* (published February 2015). The report is available at http://nuffieldbioethics.org/wp-content/uploads/Biological_and_health_data_web.pdf.

Specific comments:

- **1335-1339** Our report looks at the issues raised in relation to seeking consent for use in research (see, in particular, paragraphs 4.31 – 4.42). It is important to note that while consent acknowledges an individual's right to decide against some uses of data, it does not necessarily prevent harms occurring to them when there may be poorly understood or unforeseen consequences of data use. Where a person providing data about themselves cannot foresee or comprehend the possible consequences of how their data will be available for linkage or reuse, consent at the time of data collection cannot, on its own, be relied upon to protect all of their interests. Those who manage data initiatives therefore have a *continuing* duty to promote and protect the legitimate rights and interests of those who have provided data about themselves irrespective of the terms of any consent given.

- **1340-1346** Opt-out procedures may not always be appropriate. Much will depend on the context in which the data is being used, and how the research is governed. We would encourage those involved in setting up research initiatives not to make assumptions about pre-existing norms, but to establish what existing privacy norms are engaged by the proposed uses of data. These norms will have a number of different sources, including social conventions, value and belief systems, and the needs of individuals, groups and communities. This might include, for example, norms of professional confidentiality, of data sharing within families or social groups, or of wider acceptance of data use.

- **1355-1356** In some cases, the anonymization or coding of data will be neither desirable nor possible. We further note that de-identification of individual-level data cannot, on its own, protect privacy as it is simply too difficult to prevent re-identification. This can only be expected to become more difficult as the accumulation of data, and corresponding processing and analytical power, make potentially identifying linkages increasingly possible.

- **1357-1360** We welcome the emphasis in the commentary on community engagement, capacity building and equitable distribution of burdens and benefits. Our report concludes that public participation, alongside accountability, and backed up by good governance, is imperative to ensure that respect for participants of research and protection of their data is at the centre of any research initiative.

- **1387** It is important that any governance model is adaptive, and takes account of social norms, of individual freedoms and of professional responsibilities. We suggest an additional item for the list: appropriate mechanisms for keeping participants informed of research outcomes.

- **1466-1467** We suggest the addition of another condition: those who opt out should not be disadvantaged by doing so, for example in relation to the level and quality of care they receive compared to others.

Guideline 13: Reimbursement and compensation for research participants

General comments:

- The Nuffield Council on Bioethics report '*Human bodies: donation for medicine and research'* (published October 2011) concludes that payment for participation by healthy volunteers in first-in-human clinical trials within the UK is ethically justified.

- The major risk from the payment system to the welfare of the volunteer lies not in participation in the trial itself, but in the medical risks involved when volunteers take part in repeated, or even concurrent, trials. Further aspects of concern become relevant in countries without universal health care systems: these include the possibility that participants may not receive appropriate monitoring and follow-up care, and may not be eligible to participate on an equal basis.

- The Council therefore recommended that in order to limit the harms of over-volunteering, the registration of all healthy volunteers in first-in-human trials on a national database should be a compulsory requirement for ethical approval of such trials.

- The full report is available at http://nuffieldbioethics.org/wp-content/uploads/2014/07/Donation_full_report.pdf.

Guideline 16: Research involving individuals who are not capable of giving informed consent

General comments:

- The Nuffield Council on Bioethics report '*Dementia: ethical issues'* (published October 2009) considers the ethical issues raised by involving people with dementia in research. The full report is available at http://nuffieldbioethics.org/wp-content/uploads/2014/07/Dementia-report-Oct-09.pdf (see, in particular, Chapter 8).

- The report notes some practical challenges around involving people with dementia in research. However, the ability of people with dementia to give, or withhold, valid consent to research should not be underestimated. The information provided both in written and verbal form, however, may need to be provided in a different form for people with some cognitive impairment compared with people without such impairment. Both researchers and ethics committees should adapt the informing process in a way to enable, rather than to exclude, people with dementia in making a valid decision as to whether or not to participate in research.

Guideline 17: Research involving children and adolescents

General comments:

- These comments draw on the findings of the Nuffield Council on Bioethics report '*Children and Clinical Research: ethical issues'* (published May 2015). The report is available at http://nuffieldbioethics.org/wp-content/uploads/Children-and-clinical-research-full-report.pdf.

- Specific suggestions for amendments are set out below, but we also wish to welcome and note that we support sections of this guideline including, for example, sections **1892-1900**, **1892-1900, 1934-1936, 1968-1977** and **1983-1984.**

- We believe it would be helpful for this guideline to start with a reflection on the wide range of 'children and young people' it concerns, e.g. from babies through to those just short of legal maturity. It would be useful to acknowledge the markedly different capabilities to understand and consent to research within the range. We hope this would encourage Research Ethics Committees to take a more nuanced approach to proposals involving children and young people.

Specific comments:

- **1845/1846** - This emphasis on children's lack of ability to protect their own interests makes no reference to the role of parents (defining

parents broadly). We would argue that a 12 year old child, well supported by their parents, may be better able to protect their own interests than many an adult. We therefore suggest additional wording: '*Moreover, without appropriate parental support' etc.*

- **1847/1848** – Rather than simply stating a need for 'specific protections', we would advocate a different approach, one that first identifies how children and young people are different, and then considers how those different needs/experiences might best be addressed. (As we note in our report, involving children, young people and parents in the design of a research study can help ensure that the resulting study constitutes a 'fair offer' which researchers feel confident extending to children and families).

- **1850** – We agree that this will usually be the case. There are, however, exceptions. Our report identifies a 'Case 3' category of children and young people, who potentially have the capacity and maturity to make their own decisions about taking part in a particular research study, but who are still considered minors in their domestic legal system. There will also be cases where mature young people *cannot* involve parents, either because of the nature of the research, or because their parents are absent/living elsewhere. The guideline wold benefit from some nuancing to alert RECs to circumstances when parental consent might exceptionally not be necessary.

- **1853** – We found that requirements for 'assent' were interpreted very differently, and were often understood to mean obtaining the signing of a form by the child. We suggest that requirements for assent to be sought should be interpreted as a requirement to involve children, as much as they wish and are able to be involved, in the decision-making process. We suggest a reference to meaningful engagement with children in the guideline text. We further suggest that assent should be a question which is considered ***throughout*** the course of research (and not just at the start), rather than *one* indication of agreement at one particular point in time? We suggest stating this upfront in addition to in the explanatory note.

- **1854** - Young people who have sufficient capacity to understand what is at stake should be asked to 'consent', not to 'assent' (with co-consent from parents, as a matter of good practice, and where required by law). We suggest stating upfront that information should be provided in an appropriate manner (*how* information is provided, and the skills of the researcher communicating with the child/young person, will be the most important aspects of a good assent process).

- **1858** – We suggest referring to 'welfare' instead of 'medical alternative'.

- **1932-1933** It would be helpful to distinguish more clearly here between ethical & legal aspects of consent. Many children & young people may

be capable of giving consent for themselves - and should be invited to do so. Legal requirements for consent are likely to require parental consent, and, given the family/joint nature of decision-making for children, it is also good practice ethically for parents to be invited to consent.

- **1935 - 1936** – We suggest adding “and processes of engagement” at the end of this sentence.

- **1944 -** It is not clear here whether the guideline is referring to babies (who cannot be involved in the decision at all), or children and young people who are not able to consent themselves, but who, after being engaged in the decision-making process, are objecting?

- **1949** - This is the most obvious example of where 'welfare' concerns might demand a child's objection be over-ridden.

- **1955 – 1956** – Whilst we agree, it may potentially also be where parents believe the welfare reasons (understood broadly) for participation override respecting the child's wishes. Our report states that, in principle, decisions should always be shared ones, and if all cannot agree then the best option will be non-participation. However, we note that parents have an important role with respect to their child's welfare which may sometimes justify overriding a refusal. The more mature the child & the more firm the objection, the greater the justification required.

- **1961 – 1963** – We recommend changing this wording to state that consent is required in these cases, even if parental consent is also legally required.

- **1968-1977** – We suggest having a flag in the main guideline, pointing to this exception

- **1982** – We agree the spirit of this part of the commentary, but would question the assertion that independent child advocates are mandatory. We would suggest some flexibility in how special protections are implemented.

Guideline 20: Research in disaster situations

General comments:

- These comments draw on the ethical considerations set out in the Nuffield Council on Bioethics briefing note ‘*Zika: ethical considerations*’ (published February 2016). The briefing note is available at http://nuffieldbioethics.org/wp-content/uploads/NCOB-briefing-note-zika-ethical-considerations.pdf.

Specific comments:

- **2261-2265** Sensitivity to local conditions, and the creation of trusting relationships with local communities are of critical importance when conducting research into vaccines and treatments. Appropriate study design needs to take into account both the necessary scientific rigour and an understanding of what is locally acceptable, particularly in the absence of any effective standard treatments and widespread anxiety about the consequences of infection. We note that early discussion and collaboration with local research ethics committees will maximise the possibility of speedy consideration of innovative trial designs. Where necessary, local research ethics committees should be able to call on international support, for example, preparatory work from other countries or advice or personnel to enhance local capacity.

- **2271-2272** We agree - decisions about potentially intrusive public health measures are most likely to gain public acceptance where they are made in an open and inclusive manner; where there are clear lines of accountability; where reasoning is clear and explicit; where uncertainties are frankly acknowledged; where alternative approaches are recognised and debated; and where there is a commitment to ongoing research to improve the evidence base and reduce uncertainty. We further note that early public engagement, allowing for consideration of the interests of all potentially concerned to be recognised, can play an important part in building public trust. Social media has a potentially powerful role to play in enabling diverse public voices to be heard, and in creating a sense of solidarity between people who would not otherwise have come into contact.

- **2285** We suggest that the collection and sharing of surveillance data in these circumstances without the need for individual consent can be justified ethically on the grounds of the public interest, if carried out in an appropriate manner. This would include adequate measures being taken to respect the private interests at stake, and trustworthy governance systems put in place.