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Review Article

Informed Consent, the Ethical Cornerstone of Medical Intervention, Especially within the Conduct of Clinical Trials

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Abstract

Introduction: This paper outlines and explains a new approach to informed consent, especially within clinical trials.

Background: Autonomy implies the patient has control for what happens to his/her body. There is a problem with lack of equipoise between clinician and patient, especially when the clinician, conducting a trial, is also the patient's physician. Beran et al adopted a novel approach to informed consent, especially within clinical trials. The patient is introduced to the trial coordinator who assumes responsibility of discussing the nature, risks and benefits of the trial. If the patient accepts and signs the informed consent document, with the coordinator, the doctor counter-signs it, offering the opportunity to ask further questions, criticize the process and feel confident that the decision was correct.

Discussion: Where the investigator is also the patient's treating clinician, it must be recognized that there might be a perception of potential coercion, asking a patient to join a trial. The practice employed a trial coordinator, a recent university, science graduate, a young person with less influence over the patient. Patients completed the bulk of the informed consent with the trial coordinator, given every opportunity to decline inclusion into a trial. With the trial coordinator, being responsible for discussing the elements of the trial, there is a reduced potential for undue influence, with ultimate respect for autonomy and self-determination. This procedure offers a novel approach to gain informed consent for inclusion in clinical trials with the doctor retaining ultimate responsibility, for informed consent, and countersigning the consent document.

Keywords: Informed; Consent; Research; Intervention; Ethics; Management

Introduction

The four ethical pillars, upon which all medical intervention, but especially clinical research, is based are: Beneficence; Non-maleficence; Justice; and Autonomy [1,2]. Of these, autonomy is by far the most relevant to the doctor/patient relationship as the other three considerations often have been addressed before the patient attends the doctor, either in the form of a Human Research Ethics Committee (HREC) evaluation and directive or via the drug administration approval process [3-5]. Despite these ethical evaluative processes, there remains serious concern that much of the influence of these four pillars is lost in the clinical delivery of health care, where there is insufficient educational support to enforce their true application [3,6]. This leads to much of the respect for these four pillars of medical ethics being afforded lip service rather than that which they truly deserve [6].

Over the years, within the domain of private practice, there has been an effort to better develop clinical research and, with a combined background in medicine and law, there has emerged a novel approach to the application of informed consent [7-10]. The paper to follow will outline and explain how this approach is applied to patient recruitment in clinical trials and basic research within private practice, with the aim of providing a basis for its wider application that respects both the patient and the doctor.

Background

The concept of autonomy implies that the patient has ultimate control for that which happens to his/her body and what treatment, if any, is acceptable for that patient [11,12]. While this is the utopian impression, in reality, the application of autonomy is less forthright and straight forward than the utopian impression would imply [11,12]. Some would argue that autonomy actually hinders the delivery of optimal patient care [13], stating that, "… a strong focus on decision situations is problematic, especially when combined with a tendency to stress the importance of patients' independence in choosing. It distracts attention from other important aspects of and challenges to autonomy in health care. Relational understandings of autonomy attempt to explain both the positive and negative implications of social relationships for individuals' autonomy. They suggest that many health care practices can affect autonomy by virtue of their effects, not only on patients' treatment preferences and choices, but also on their self-identities, self-evaluations and capabilities for autonomy. Relational understandings de-emphasize independence and facilitate well-nuanced distinctions between forms

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of clinical communication that support and that undermine patients' autonomy…" [13].

While providing lip service to the concept of autonomy, there is a relative disregard for the lack of equipoise between the patient and the doctor [14]. It has been stated, with particular relevance to clinical trials, "…Some doctors espouse the uncertainty principle whereby randomization to treatment is acceptable when an individual doctor is genuinely unsure which treatment is best for a patient. Others believe that clinical equipoise, reflecting collective professional uncertainty over treatment, is the soundest ethical criterion…" [14]. What this reflects is the dilemma facing the clinician, especially when conducting clinical trails. This difficulty is greatly enhanced when the clinician, conducting a trial, is also the personal physician for the patient [7-10]. There can never be a real equipoise, between doctor and patient, as the doctor is the receptacle of the relevant knowledge which must underpin the patient's decision making and which directly influences how that patient may choose to proceed [15,16]. It has been stated that, "… factors influencing patient participation consisted of: factors associated with health care professionals such as doctor-patient relationship, recognition of patient's knowledge, allocation of sufficient time for participation, and also factors related to patients such as having knowledge, physical and cognitive ability, and emotional connections, beliefs, values and their experiences in relation to health services…" [15]. It follows that, in reality, there is no optimal position, especially if it is the doctor who is also responsible for obtaining informed consent. There is no doubt that awareness of the responsibility is gaining influence [16]. It also is recognised that this is not without its problems. At stated by Zolkefli [16], "…Popular concepts such as patient-centered care, patient empowerment, and patients as partners, shared decision making, and informed choice illustrate the emancipation of patient ..(BUT).. choice is not necessarily a good thing in healthcare…"

What this discussion has produced is an emphasis on the dichotomy that exists within the medical profession regarding patient autonomy, especially as it relates to informed consent [17]. It cannot be ignored that each doctor brings to the table his/her personal baggage with regards to patient autonomy and this will directly influence how such informed consent, or rejection, of therapy, especially in the face of what are considered to be the myths surrounding informed consent [18]. These, so called myths, include: "…1) decision-making capacity and competency are the same; 2) lack of decision-making capacity can be presumed when patients go against medical advice; 3) there is no need to assess decision-making capacity unless patients go against medical advice; 4) decision-making capacity is an "all or nothing" phenomenon; 5) cognitive impairment equals lack of decision-making capacity; 6) lack of decision-making capacity is a permanent condition; 7) patients who have not been given relevant and consistent information about their treatment lack decision-making capacity; 8) all patients with certain psychiatric disorders lack decision-making capacity; 9) patients who are involuntarily committed lack decision-making capacity; and 10) only mental health experts can assess decision-making capacity…" [18]. These 'myths' further add weight to the broad arguments that surround informed consent and further 'muddy the water' when it comes to decision making processes for which informed consent was to be the pivotal corner stone.

Acknowledging the lack of equipoise, in the doctor/patient model, while concurrently accepting the need to offer the patient the opportunity for truly independent informed consent, to be accepted for inclusion into a clinical trial, Beran et al adopted a novel approach in which the doctor played less of a pivotal role in obtaining informed consent and was only involved in the initial and concluding exchanges with the prospective trial candidate [7-10,18-20]. The initial approach to the patient was to ask the patient if (s)he was willing to consider inclusion in a clinical trial. To allow an informed decision, at this time, the broadest of outlines of the prospective trial were exchanged with the patient(s) and (s)he assured that any decision, made by the patient, at the time of this initial discussion would, in no way, affect ongoing doctor/patient relationship, other than possibly deny that patient access to a new form of treatment that would be otherwise not available outside the confines of a clinical trial. If the patient indicated a willingness to learn more about the trial (s)he was introduced to the trial coordinator who was a young scientist, recently graduated from university. This approach removed the potential for undue influence that might be imposed by the 'grey haired professor' who may be perceived as having a financial interest in rapid trial recruitment and, as the patient's treating physician, may be seen as being disappointed with a patient refusing inclusion within a trial [20].

Replacing this potential coercive imposition, as might be perceived by the patient, of his/her treating doctor, this novel approach has, to some extent, reimposed a level of equipoise that was otherwise not available. The trial coordinator who assumed the responsibility of discussing the nature and risks and benefits of the trial, in accordance with the patient information and informed consent documentation, as already vetted and approved by the HREC, prior to the trial being approved to be undertaken with human subjects. These documents were previously submitted to the HREC to ensure that the language used was suitable for general consumption; devoid of unnecessary jargon: and that, the content was sufficiently comprehensive to ensure that the prospective trial participants were informed adequately of the risks and benefits of the proposed clinical trial. Where problems arose with this prepared documentation, this had to be addressed before the trial was given the green light to proceed by the HREC.

The trial coordinator was under strict instruction to ensure that every line of the approved documentation was explained in detail, without any undue influence being applied. The prospective trial participants were offered every opportunity to ask as many questions as required and be assured that (s)he fully understood that which was presented. Where necessary, (s)he was provided with a copy of the documents to take away and to discuss with family or advisors. Where this was the case, an appointment would be made, for a week or so later, to offer adequate follow up, initially with the trial coordinator, to answer unanswered questions. By this stage, the prospective participant was assumed to be in a position to make an informed decision whether, or not, to enrol into the trial. If willing to proceed with the trial, the patient would be asked to sign the patient informed consent form, in front of the trial coordinator, in the presence of a witness, to ensure that the patient's signature was not coerced in any way.

Irrespective of whether the patient wanted to be included within the study, or not, (s)he would be sent back to the doctor for ongoing care. Should the patient refuse entry into the trial, this was not further

revisited, once the trial coordinator informed the clinician that the patient did not want to proceed. In this situation, the patient's medical management continued as if (s)he had never been referred to the trial coordinator and reference to the trial was no longer relevant to ongoing care. Where the patient indicated a wish to proceed with the trial, the doctor would offer an opportunity to answer any further unanswered questions, in relation to the trial, and, having done so, the patient also would be offered the chance to criticize the methodology of seeking informed consent and if (s)he was satisfied that the decision, to be included in the trial, was unequivocally an expression of his/her free will, devoid of undue influence.

If the response to all these issues was in the affirmative, the process of informed consent was concluded with the doctor counter-signing the informed consent document. This additional signature was more than an act of showmanship and was an act of recognition of the fact that, as the principal investigator at this site, it remained the obligation of the senior investigator, at this site, to confirm that the informed consent process was satisfactorily concluded. The additional signature was acceptance of the investigator's responsibility to maintain the highest of standards and to accept that, while the bulk of the informed consent process was conducted by a young scientist, acting as the trial coordinator, the legal obligation of the investigator should not be completely delegated to someone else, without accepting the added quality assurance of the investigator assuming the final role of administering informed consent.

Discussion

There is a general acceptance that informed consent is a basic ethical condition that underpins medical care, to allow the patient the right to determine that which (s)he allows to occur to his/her body [1,2]. Having so acknowledged this basic patient right, it is less easy to ensure that this right of informed consent is fully respected when delivering medical care [3,4,6]. This is even more so within the context of informed consent when including patients into clinical trials [7-14].

Where the investigator who is recruiting patients into a clinical trial is also the patient's treating clinician, it is difficult to guarantee that there is a real lack of undue influence [18-20]. It must be fully recognised that there might be a perception of potential coercion that may attach to the doctor asking his/her patient to be part of a trial. The fact that the patient is being offered inclusion into a trial may be seen as imposing the expectation that the patient will please his/her doctor by accepting the offer, thereby enhance recruitment into the trial [7-10,18-20]. The fact that a trial offers the patient access to a remedy that is probably not available outside the confines of a trial is not always fully appreciated.

To counter any perception of possible coercion, Beran et al. [7-10,18-20] developed a novel approach to obtaining informed consent, from patients being offered inclusion into clinical trials which were being conducted within the practice. The practice employed a research assistant who acted as a trial coordinator, monitoring clinical trials being conducted within the practice. This person, acting as trial coordinator, was a recent university, science graduate that translated to the trial coordinator being a young person with less influence over the patient and often considerably younger than the patient, being invited to be part of a clinical trial. Involving the trial coordinator, in the process of obtaining informed consent, meant that the doctor played a far less influential role in gaining informed consent and removed the potential that inclusion was a mandatory component of ongoing patient care [18-20]. The patient was encouraged to complete the bulk of the informed consent process with the trial coordinator who translated the pre-approved patient information sheet and obtained the initial signature on the informed consent document (also preapproved by the HREC) prior to the patient returning to the doctor to finalize the consent procedure. The patient was given every opportunity to decline the offer, of inclusion into a trial, without the potentially coercive involvement of the treating doctor. The doctor was usually older than the patients, involved in the process, thereby introducing the element of respect for one's elders and particularly respect for someone with potentially greater influence and standing in society. It follows that just being the patient's doctor might have been sufficient to influence the patient to agree to be recruited to a trial, even if, in reality, the patient did not want to be part of it.

With the trial coordinator, being responsible for discussing the elements of the trial, the expectations, inclusion and exclusion criteria, the risks and possible benefits and answering the patient's questions, translated to the patients being able to ask questions without the fear of disappointing nor looking ignorant in front of their doctor. There is a reduced potential for exerting undue influence, within this scenario, and the patient has been shown the ultimate respect for autonomy and self-determination. Once the patient has decided to either proceed with the trial or rejected same, (s)he was referred back to their doctor who would either conclude the informed consent protocol, by countersigning the consent form, once the patient had reaffirmed willingness to be included into the trial and had indicated that all outstanding questions have been answered, or alternatively (s) he had indicated lack of will to join the trial [18-20].

In either case, the patient has avoided any potential to be coerced to participate in a trial, yet the doctor has not totally delegated the informed consent process as (s)he has acknowledged his/her responsibility, as the chief investigator at the site, by providing the final signature to demonstrate conclusion of the consent process. Should the patient reject trial inclusion, the fear of disappointing the doctor largely has been removed because it was the trial coordinator who discussed the trial with the patient. This procedure offers a novel approach to gain informed consent for inclusion in clinical trials. While the doctor still retains the ultimate responsibility for informed consent, (s)he is at 'arm's length' in advising the patient what is required of them in the trial and the potential risk/benefit ratio, while still being the last 'port of call' to ensure that the process offered ample opportunity to discuss any concerns without perceived imposition of undue influence.

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