

The Perspectives Study

Guidance to inform recruitment and consent in studies involving critically ill patients

Version 1, April 2020

An online version of this guidance is available at: <https://www.liverpool.ac.uk/population-health-sciences/departments/health-services-research/research/perspectives/resources/>

Foreword

Critical illness is a very distressing experience for patients and their relatives. There are so many difficult, upsetting and sometimes frightening aspects to it. The critical illness may have been unexpected, so unlike some other treatments or hospital stays, it cannot be prepared for. Patients may experience confusion, delirium, unpleasant medical procedures and be unable to communicate. Relatives are thrown into a world that seems so alien, and crucially, it may be unclear for quite some time whether the patient will survive, and if they survive, what life will be like afterwards. Imagine then, during this time, to be approached and asked about taking part in a medical research study. It is likely the patient may be too ill to be able to say whether they'd like to be involved, so relatives will be asked to decide on their behalf. At a time of such distress, it's hard to even make simple self-care decisions, let alone anything more complicated. And yet, it's because of such studies that critical medicine continues to find out what are best treatments for critical care patients, which results in better outcomes and can save lives..

In 2018/19 the National Institute of Health Research supported 104 Critical Care studies and 41000 patients were recruited. That means there were at least 41000 conversations about these studies with patients and relatives in the UK last year. Healthcare professionals will learn from their own practice, and that of their colleagues, about how to talk about research with patients and relatives at such a challenging time. These conversations require very skilled communication, but until now there has been no official guidance to best practice.

I first heard of the Perspectives Research project in 2016. I thought then, and continue to think, what an innovative and important piece of research it is. Innovative because asking those involved in research (patients, relatives and healthcare professionals) about their experiences hasn't been done before on this scale (the research team heard the views of 1400 people). Important because the priority must be to make this experience as comfortable as possible for patients and relatives, and best practice guidance will help this.

Perspectives found real support from patients and relatives about the importance of critical care research. This is encouraging, but I think there is still much more to do to raise awareness among the general public about the role of research and why it matters. The more people know about it, the less of a surprise it will be if you are approached about it in an ICU. And believe me, a surprise is the last thing you need at that time. I also think that some of the most notable recommendations are about approaching bereaved relatives. It might be hard for healthcare professionals to know the best way to do this, but it is so important.

So thank you for reading this guidance. I hope it will be used by research staff to add to the good practice that is already out there. I hope that it will prompt reflection and conversation about current processes and what could be done better. But I think it also needs to be seen as the start of a continuing conversation, one which will encourage new patient and relative centred research in this area and evolve as new evidence is added. This will ensure that the process of research works for all stakeholders, but particularly for patients and their relatives.

Catherine White

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Glossary of terms and abbreviations

Capacity	Someone has capacity when they are able to make their own decisions. Someone lacking capacity cannot do one or more of the following: understand information given to them about a particular decision; retain that information long enough to be able to make the decision; weigh up the information available to make the decision; communicate their decision.
CTIMP	Clinical Trial of an Investigational Medicinal Products (e.g. drug trial).
Equipoise	This is when there is uncertainty about which treatment is best and there is no good basis for a choosing one treatment over another in terms of their effectiveness.
Emergency and non-emergency research	<p>These terms are in widespread use, but what is defined as an emergency versus non-emergency in a research context is often not clear. This guidance uses the term emergency research when a treatment needs to be given urgently and there is no time to seek informed consent for a study. This definition is used by the Health Research Authority and is closely aligned to the wording of clinical trials legislation.</p> <p>However, emergency research can also be considered to include situations when a study activity does not itself involve treatment (e.g. the activity is for data collection) but it has to happen before an urgent clinical intervention already in progress is complete, or the study activity has a short time window and delaying recruitment to gain consent would invalidate the study. Emergency research usually relates to a fairly specific timeframe, but the justification for when it's appropriate to use RWPC can vary from study to study in accordance with the potential benefits and harms also varying between studies.</p>
HRA	Health Research Authority. Their role is to protect and promote the interests of patients and the public in health and social care research and are one of several organisations that work together in the UK to regulate different aspects of research. Most of their work applies to research undertaken in England, but they also work closely with the other countries in the UK to provide a UK-wide system.
ICU	Intensive care unit, also known as critical care.
Non-CTIMP	Any study that does not involve an investigational medicinal product is a non-CTIMP (not a drug trial). Examples of non-CTIMPS include medical device trials and observational studies that involve data collection only.
PPI contributors	PPI stands for patient and public involvement. PPI contributors are members of the public, such as patients and family members, who work with researchers to improve the design and conduct of research.
Personal consultee	Used in non-CTIMPs to refer to a someone who cares for the patient (not professionally or for payment), or is interested in his/her welfare, and is prepared to be consulted about the study. It is usually a family member or a close friend.
Personal representative	Used in CTIMPs to refer to a person not connected with the study who is suitable to act as the legal representative by virtue of their relationship with the patient, and is available and willing to do so. It is usually a family member or a close friend.
Prospective patient consent	This is when informed consent is sought from patients before they take part in a study.

Professional consultee	A person who is independent of the study appointed in accordance with the Department of Health's guidance on nominating a consultee for research involving adults who lack capacity to consent.
Professional representative	A doctor responsible for the medical treatment of the patient if they are independent of the study, or a person nominated by the healthcare provider.
RWPC	This stands for Research Without Prior Consent and is used in emergency research where there is no time to seek informed consent before research participation.

Who is the guidance for?

The guidance is for all those who have a direct or indirect role in the funding, design, conduct, governance, and ethical review of critical care studies involving adults. This includes: doctors, nurses, paramedics, researchers, patient and public involvement (PPI) contributors, members of research ethics committees, study sponsors, funding committees, peer reviewers, and clinical trial unit staff. The guidance will also be of interest to patients, family members, study sponsors, NHS Research and Development (R&D) staff, other members of the public and to organisations that represent the interests of patients and the public.

What is the scope and purpose of the guidance?

This guidance has been developed to assist the design, review and conduct of studies conducted in UK adult critical care settings. It can be used to inform the development of new study protocols, or in conjunction with a study's existing protocol that has been approved by an ethics committee. The guidance focusses on studies involving the recruitment of patients lacking capacity (please see Glossary of Terms page 4) due to critical illness and treatment, or due to pre-existing conditions.

The recommendations in this guidance are primarily based on findings from the Perspectives Study. Perspectives is the first large-scale UK study to explore the views of stakeholders, and specifically those of patients and families, on recruitment and consent in adult critical care situations. Some of the recommendations add to current practice in studies conducted in critical care, while other recommendations confirm the acceptability to stakeholders of current practice in critical care and of wider guidance on research in healthcare settings (see Box 1 for outline of current practice). Given the previous limited evidence on UK stakeholder perspectives about research in critical care, we believe it is crucial to include such confirmatory recommendations in this guidance, particularly as these were often about topics that were important to stakeholders.

Perspectives Study participants were recruited from English hospitals All recommendations are compliant with English and Welsh legislative frameworks and should be used with close reference to those (we outline these frameworks in Appendix 1). While Scottish and Northern Irish frameworks differ to those in England and Wales, we expect the guidance to be broadly transferable throughout the UK and beyond.

Box 1. Outline of current critical care recruitment and consent processes

The Perspectives study provides a new evidence base confirming the acceptability of most current critical care recruitment and consent processes. In general terms it endorses the following existing practices:

- Where a patient has capacity at the point of recruitment to a study, seek their informed consent.
- Where a patient lacks capacity at the point of study recruitment, consult with family members/seek their consent before the patient is entered into a study where possible. Where a patient subsequently regains capacity, their consent should also be sought.
- Where no suitable family members are identified and contactable, it is acceptable to use a professional consent or consultee process. Where a patient subsequently regains capacity, their consent should be sought.
- Where there is not time for personal or professional consent (e.g. in an emergency) it is acceptable to enter the patient into a study without prior consent.

Please see Figure 1 (page 40), a flow chart of decision points in recruitment and consent to critical care studies.

Why is guidance needed specifically for ICU studies?

Clinical research involving critically ill patients is essential for improving care and treatments for this population. However, the process of recruiting and seeking consent in critical care settings is different to many other settings, as studies frequently take place within a narrow time window and patients will often be unable to consent due to lack of capacity. The ‘gold standard’ model of an autonomous patient who is able to give fully informed prospective

consent is often not applicable. Alternative processes for recruiting and seeking consent for these patients have been developed, which aim to balance the rights of critically ill patients with the need to avoid impeding research that is essential for improving treatments for such patients in the future. Appendix 1 provides an overview of recruitment and consent legal frameworks and processes for both Clinical Trials of Investigational Medical Products (CTIMPs) and other study types (non CTIMPs) in England and Wales, as set out by the Health Research Authority (HRA, 2013, 2018, 2019).

While resources on legal frameworks such as those summarised in Appendix 1 are available to ICU research teams, implementing these can be challenging in clinical practice. Conversations about research participation may not seem a priority to patients and family members, who are already overwhelmed and struggling to absorb information about the clinical situation. Family members may feel unprepared and uneasy about making decisions about research participation on behalf of their relatives. Meanwhile doctors and nurses have the responsibility for explaining research to patients and families in these daunting circumstances. We hope that this guidance helps to bridge the gap between the legal frameworks and the realities of ICU studies for all involved and help ensure that research processes are patient centred.

What type of ICU studies is this guidance for?

This guidance has been developed for UK research studies in both emergency and non-emergency adult critical care situations¹. However it may also benefit service users and researchers internationally.

How has the guidance been developed?

As we note above, the recommendations in this guidance are primarily based on findings from the Perspectives Study, which was conducted between 2017-2019 in 14 hospitals in England. The study researched the views of over 1400 stakeholders (patients, family members, doctors, nurses and researchers) on recruitment and consent in ICU studies (see Appendix 2 for details). We are grateful to everyone who participated and have incorporated what they told us into the guidance to help ensure recruitment and consent to critical care studies reflects the needs and priorities of all these groups.

¹ Some recommendations in the guidance refer to studies where patients are randomised at the individual rather than cluster (group) level.

We further outline the methods used in the study in Appendix 2, and list the study team and advisory group members in Appendix 3. Statements of the key evidence considered when developing the recommendations are shown in Appendix 4. In addition to the Perspectives Study findings, this guidance was also informed by a review of other research evidence and ethical analysis.

In developing the recommendations, we have referred to the legislation for the various types of critical care studies (i.e. both CTIMPs and non-CTIMPs). The terminology used to refer to patients, staff and family members varies between the different pieces of legislation, and researchers, families and patients also use different phrases and terms. We have tried to ensure that the terms we use in the guidance are as user friendly as possible. We provide footnotes on additional legislative information and terminology where clarification seemed helpful.

In October 2019, this guidance was reviewed and developed in consultation with 28 people (including ICU practitioners, ethicists, former ICU patients and family members with ICU experience) who attended a one-day meeting in Liverpool.

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Recommendations

SECTION 1. PRE-RESEARCH ACTIVITY

Recommendation 1: Tailor the design of recruitment and consent procedures to the ICU setting, patient capacity and the nature of research activities (see Appendix 4, [Section 1](#), p. 26, line 4).

- When designing a study, research teams should consider which recruitment and consent processes are most appropriate and ensure adequate resourcing is in place, including staffing. This should include a review of the setting, anticipated time window available for consent procedures and capacity of eligible patient population. Consider whether or not the research activity (e.g. intervention delivery, data collection) will involve incapacitated patients and/or take place in an emergency situation and develop appropriate processes including: prospective informed consent, consent by a personal or professional representative² in the case of CTIMPs, or personal or professional consultee³ processes in the case of non-CTIMPs.
- For research in emergency situations, research without prior consent (RWPC) is usually considered appropriate when research activity needs be administered urgently (e.g. straight away) and it is not reasonably practicable to obtain informed consent from a representative, or hold a discussion with a consultee prior to entering the patient into the study. Other conditions apply, please see Appendix 1 and relevant legislation. If the study involves only data collection (i.e. observational studies) consider whether consent will be required and how patients will be informed about the study⁴. If consent is required from patients after they have regained capacity, consider providing them with the option of documented verbal consent if the patient would physically struggle to sign the consent form.
- When developing study protocols and site training materials, clearly specify the anticipated maximum time window for patient eligibility and for approaching patients or family members. This is essential for research staff to initiate appropriate consent and consultee processes.

² Referred to as Professional Legal Representative or Personal Legal Representative in CTIMP legislation

³ Referred to as Personal Consultee or Nominated Consultee in Non CTIMP legislation

⁴ Section 251 approval is needed if data is not fully anonymous, which we can be sought via the Confidentiality Advisory Group (CAG). Disseminate GDPR Transparency wording to data subjects “within a reasonable period after obtaining the personal data, but at the latest within one month” (GDPR Article 14, paragraph 3(a))

- Consider conducting pre-study research (e.g. feasibility study) and PPI to refine the research questions and establish acceptability of the proposed study and recruitment and consent processes to key stakeholders (e.g. patients, family members, clinical and research staff). Such insight can inform the development of the study protocol and research ethics committee application, including the use of consent processes (e.g. RWPC and personal or professional/consultee processes. See further information at <https://www.hra.nhs.uk/planning-and-improving-research/best-practice/public-involvement/> <https://pilotfeasibilitystudies.biomedcentral.com/articles/10.1186/s40814-015-0026-y>).

Recommendation 2: Actively involve patients and family members in the design of your study and information materials (see Appendix 4, [Section 1](#), p. 26, line 21).

- At an early point in planning, facilitate and actively involve PPI contributors with relevant experience of critical illness as a patient or family member in the design of study processes, procedures and materials. This is important to inform aspects of a study such as the aims, design and development of recruitment and consent procedures, selection of outcomes, patient and family member information materials (including the identification of what languages written information materials should be translated into and staff training - see further information at: <https://www.invo.org.uk/>).
- Study teams should invest time and consider resources required to actively involve and support PPI contributors for critical care studies. This may include publicising opportunities for people to be involved in designing ICU research or providing bespoke training on aspects of ICU research, such as the different process and requirements related to consent with incapacitated patients and emergency situations.
- The plain language animation on consent to ICU studies (<http://shorturl.at/mrK26>) produced as part of the Perspectives study, may be helpful for PPI contributors.

Recommendation 3: Written study information must be easy to understand and access. It should include information relevant to patients, and personal and professional representatives/consultees (see Appendix 4, [Section 1](#), p. 27, line 1).

Here we focus on matters specific to ICU research. For general advice on producing information materials etc. see HRA guidance <https://www.hra.nhs.uk/planning-and-improving-research/best-practice/informing-participants-and-seeking-consent/>.

- Ensure participant information materials (including information sheets and leaflets), consent forms and declaration forms for different roles (patient, personal representative/consultee, professional representative/consultee) and include information about their specific role in decision-making.

- Include a short summary section to assist the tailoring of information to the capacity of patients and personal representatives/consultees and avoid information overload.
- Provide the option of access to online participant information materials (e.g. via links in patient ICU diaries to study websites). Hard copies of documents can be lost during the ICU stay and patients/family members (including friends and carers⁵) may wish to keep all information about their/the patient's ICU stay. Consider using ICU patient diaries to record studies for patients to review later if they wish and when they feel able to.

SECTION 2. NON- EMERGENCY RESEARCH INVOLVING A PATIENT WHO HAS CAPACITY

Recommendation 4: Establish a strategy for timing the approach to patients about research participation (see Appendix 4, [Section 2](#), p. 27, line 28; [Section 3](#), p. 33, line 14).

- Often ICU patients will lack capacity at the point of recruitment and it will be necessary to approach them post-recruitment, although sometimes prospective informed consent for research can be sought from patients. In both cases, research staff should establish when is an appropriate time to approach a patient by using their professional judgement, consulting the clinical care team and/or family members and asking the patient if they feel able to have a conversation about research.
- The outcome of this consultation with the clinical care team about timing should usually be recorded in the patients' clinical notes. If the patient is recruited to the study, this should usually be noted in the patient's ICU diary.
- If research staff are uncertain about the capacity of the patient, this should be assessed at the time a decision is required by an appropriately qualified health professional or researcher. See Box 2 below for a summary of the process for assessing capacity.
- Before the research is discussed, staff should ensure the patient has had an update about their condition.

⁵ People closely concerned with the patients welfare but who are not related may act as personal representative/consultee under relevant legislation.

Box 2: Summary of the two stages in assessing capacity

The Mental Capacity Act requires a two-stage assessment of capacity that must be properly documented.

The first stage involves considering whether there is an impairment of, or disturbance to, the functioning of the patient's mind or brain.

The second stage involves considering whether the impairment or disturbance is sufficient that the patient is unable to make a decision about the particular study. This second stage is determined by answers to the following questions:

- i) can the patient understand the information relevant to the decision
- ii) can the patient retain that information;
- iii) can the patient use or weigh that information as part of the process of making the decision;
- iv) can the patient communicate their decision by any means?

(For further guidance on assessing capacity see section 1.4, p19-24, in NICE guidance <https://www.nice.org.uk/guidance/ng108>).

Recommendation 5: Use a structured approach when discussing research with patients and seeking their consent (see Appendix 4, [Section 2](#), p. 27, line 28; [Section 3](#), p. 28, line 20).

- Before discussing the research, staff should introduce themselves, clarify that they are acting in a research capacity and not a clinical capacity, and acknowledge the difficulty of the patient's situation and/or what they have been through.
- It is important for research staff to ask the patient and have agreement that they are ok to have this conversation and then clarify the following:
 - Your role within the study (e.g. study recruiter/Principal Investigator).
 - The distinction between the research activities and routine clinical care e.g. by pointing out which activities or procedures are/were for the research and so different or additional to usual clinical care.
- At an early point in the conversation with patients, research staff should explain why their consent was not sought before being recruited to the study e.g. that they were unconscious at the point recruitment needed to take place. They might also explain about the consultee process/professional consent that was used.
- Study information provided should be tailored to the capacity and understanding of the patient. Be prepared to repeat information because patients may not always fully comprehend information when first given. This may involve going back to the patient on a number of occasions unless the patient indicates they do not want to be consulted

further.

- Consider using multimedia resources e.g. animations or videos to support information provision in ICU studies to supplement written information leaflets and discussion.
- If a patient declines consent, explore any additional information needs or potential misunderstandings. There should be no expectation that on the basis of this additional information the patient should change their mind.

SECTION 3 NON-EMERGENCY RESEARCH INVOLVING A PATIENT WHO LACKS CAPACITY AT THE POINT OF RECRUITMENT

Recommendation 6: Establish and record a strategy for timing the approach to family members about a patient's research participation (see Appendix 4, [Section 3](#), p. 28, line 6; also see Recommendation 8).

- Research staff should approach appropriate family members to discuss research at the earliest appropriate opportunity. In doing so they should consider when is an appropriate time to discuss research. When establishing appropriate timing, consider the following:
 - Have the patients' family members recently arrived in the ICU for the first time?
 - Has the patient's condition recently deteriorated?
 - Have the family members recently received bad news?
 - Are the family members awaiting the results of important tests or scans?
- Where possible, consultation with nursing, medical staff, or checking notes about the patient's condition and their views on how they or their family members are coping is likely to be helpful in gauging when is an appropriate time. Where possible, record the outcome of the discussion with nursing staff about appropriate timing in the patients' clinical notes.
- If possible, ask a member of staff known to the family to introduce you and ask family member if it is a convenient time to discuss research.
- Ensure family members have been informed or had an update about the patient's condition, or suspected condition that makes them eligible before approaching them about research. Be prepared to repeat information because family members in shock may not always fully comprehend information when first given.
- Identify who is the most appropriate person to act as the patients' personal legal representative for written consent, or to be a personal consultee. This is likely to be the patients' next of kin, person with power of attorney, close friend or family member.

Recommendation 7: Use a structured approach when discussing research with family members (see Appendix 4, [Section 3](#), p. 28, line 12; also see Recommendation 6).

- When introducing themselves staff should clarify that they are acting in a research capacity and not a clinical capacity.
- Before discussing the study, research staff should acknowledge the difficulty of the situation for the family and what they are going through, and ask family members what they understand about their relative's condition.
- During this initial discussion it is important for research staff to have agreement from family members that they are ok to have this conversation and then clarify the following:
 - The aims of the research, your role within the study (e.g. study recruiter/Principal Investigator) and whether or not you are part of the clinical team responsible for treating the patient.
 - Why you are approaching them at this point in time.
 - That the research nurse/research team have spoken with the clinician in charge of the patient's care and they have assessed that the patient is eligible for participation.
 - Clearly explain to the family member how the research will/may impact on the patient's care. This might include pointing out which activities or procedures are for the research and so different or additional to usual clinical care. For example, if phlebotomy for blood samples is required, clarify the amount of blood to be taken, the family's perception of the risk of the phlebotomy in the context of the patient's condition and whether or not the sample would require venepuncture (incision in the vein with a needle) that is additional to usual clinical care.
 - That you are asking the family member to consider the study information provided and come to a view about whether the patient would wish to take part, rather than seeking the family member's own views about the study.
 - Consider using multimedia resources e.g. animations or videos to support information provision in ICU studies and to supplement written information leaflets and discussion.

Recommendation 8: Consider using collaborative research discussions to assist family decision making about their relative's participation in ICU research (see Appendix 4, [Section 3](#), p. 29, line 3).

- Legislation and guidance presents consent/consultee discussions with family members as separate to consent/consultee discussions involving research staff. However, collaborative discussions between families and the research team could assist family decision making, including establishing what is in the patients' best interests. These discussions do not necessarily have to include all staff and family members in the room at the same time, rather whatever is practically possible. Such discussions could also help to identify who should act as the consultee or legal representative for consent purposes (for example, if there is difficulty identifying who is next of kin). If practically possible, this collaborative discussion could include the professional consultee and/or a member of the clinical care team who is independent from the research, who maybe named in the participant information sheet.
- It is appropriate to offer to support personal consultees/representatives in coming to a decision by responding to any queries or concerns.
- If a personal representative declines consent or consultee advises against study participation, identify any additional information needs or misunderstandings. There should be no expectation that the family member should then change their mind.

Recommendation 9: Use a professional consent or professional consultee process when family members are not contactable or have stated they are too upset to discuss research, and/or do not wish to make a decision (see Appendix 4, [Section 3](#), p. 30, line 17).

- Make all reasonable efforts to contact family members (or close friends) to discuss the research within the study recruitment window. Face to face discussions are preferable to telephone calls. However, telephone calls are preferred to no consultation at all.
- Where reasonable efforts have been made to reach the family but they cannot be contacted within the recruitment window, or when contacted families have stated they are too upset or do not wish to make a decision use a professional consent or professional consultee process.
- Research staff should inform family members about the patient's participation in the study at the earliest appropriate opportunity. As well as providing them with information about the study, they might also explain the professional consent/consultee process and why this was used and how the patient will provided with study information if/when they regain capacity.

SECTION 4. ADDITIONAL CONSIDERATIONS FOR EMERGENCY RESEARCH WITH A PATIENT WHO LACKS CAPACITY

Recommendation 10: Establish a strategy for approaching and structuring discussions with patients (if they regain capacity) about research after the initial emergency has passed (see Appendix 4, [Section 4](#), p. 33, line 22).

- If the patient regains capacity once the emergency has passed, seek consent or consult for continued participation in the study and disclosure of confidential information to the research team. Provide details of any study follow up procedures (if applicable).
- Research staff should ensure that patients are provided with study information at the earliest appropriate opportunity, within a maximum recommended timeframe, which should be on a study by study basis and specified in the study protocol (see section 1).
- When approaching patients, first acknowledge the difficulty of their situation and what they have been through.
- At an early point in the conversation with patients, research staff should explain why consent was not sought, or why they were not consulted, before the patient was entered into the study. This should include explaining that it was not possible to hold the conversation before study recruitment because the patient needed immediate clinical care, which could not be delayed. Be prepared to respond to concerns about the patient's participation in the study or any impact on the patient. Offer patients with an opportunity to speak to the principal investigator, professional legal representative/consultee or senior member of the research team to discuss any concerns. Ensure the patient also has time to discuss the research with family members.
- Explain that the decision reached about whether to continue to take part in the study will not impact on the quality of their/their relatives' care.
- Explain that the study has been approved by an independent research ethics committee whose role is to review research to help protect the rights, safety and well-being of research participants.
- If the patient continues to lack capacity once the clinical emergency has passed, then consult with family members or seek their consent for the patient's continued

participation in the study and disclosure of confidential information to the research team⁶.

Also see recommendations 5 and 6. While recommendations 5 and 6 are about non-emergency research, they contain points that are relevant to approaching patients and families to discuss emergency research.

SECTION 5. DISCUSSING ICU RESEARCH WHEN A PATIENT HAS DIED

Sometimes patients enrolled in a study under an emergency or professional consent/consultee process may die before the study is discussed with family members. There will therefore be situations where bereaved family members are unaware that their family member has participated in a study and that their data will be included. Although there is no legal obligation to discuss research participation with bereaved family members (unless the study involves disclosure of confidential information⁹) evidence from the Perspectives Study, and previous research with bereaved parents in paediatric critical care studies, indicate that families wish to be informed about their family member's research participation.

The following recommendations are tentative until further research has been conducted.

Recommendation 11: Consider informing bereaved family members of the patient's recruitment to a study (see Appendix 4, [Section 5](#), p. 34, line 10).

- Use your professional judgement on if, when and how to approach and discuss research with bereaved family members. The approach should be consistent with the ethically approved study protocol, take place as soon as practically possible, and complement bereavement guidance at each participating hospital. If it is considered not appropriate to inform bereaved family members, document the reason in the patient records.
- Discussing research participation with bereaved family members will require considerable care. While all research discussions should be personalised and conducted with sensitivity, this is especially true of discussions with bereaved family members.

⁶ Ensure confidential information is not shared outside of usual care team until consent/consultee declaration is in place. If this is declined, then the research team must be informed, but no information on the patient can be disclosed to them.

- The Principal Investigator and/or medical/nursing staff known to the family should aim to establish which of the following options is most appropriate for each family:

Option 1: Approach family members with study information before they leave hospital.

Discuss the study and provide information before family members leave hospital. However, only approach family members at this point if it is believed to be appropriate and local bereavement guidance has already been followed.

Option 2: Contact family members to arrange a face to face discussion.

- If it is not thought appropriate to discuss the study before family members leave the hospital, consult with colleagues to identify an appropriate time to contact family members by a personalised letter or telephone to provide the option of a face to face visit to discuss research.
- If a letter is used, these should be written at the trial design stage in close consultation with bereaved family members/bereavement specialists/relevant interest groups. The letter should be personalised, signed by a clinician (known to the family if possible), include a named contact and telephone number and emphasise how a face to face meeting is optional. If they do not wish to have a face to face meeting, offer to send written information about the trial and provide contact details in case the family want to discuss the research at a later date.
- During face to face discussions explore family members' views and understanding of the study and explain why family members were not consulted/consent was not sought, prior to the patient's enrolment so that any concerns can be addressed.
- Seek consent/consult family members for disclosure of confidential information to the research team⁷.
- Be prepared to respond to family members who are concerned that study participation may have contributed to their relative's death.

⁷ Section 251 Approval may be required (via CAG) for research team to receive confidential data for deceased persons.

SECTION 6: DISSEMINATION OF STUDY FINDINGS TO PATIENTS AND FAMILY MEMBERS

Recommendation 12: Offer patients and family members the opportunity to access summaries of study findings (see Appendix 4, [Section 6](#), p. 35, line 7).

- Ensure patients and families members are provided with the opportunity to access the study findings online, particularly plain language summaries of findings, in line with study protocol and research ethics approvals. Many studies take several years for the findings to become available, so manage patients' and families' expectations about the study results becoming available in line with anticipated timescales.
- Consider using accessible, patient friendly ways of summarising study findings (e.g. animations, infographics, videos).

SECTION 7: RAISING PUBLIC AWARENESS ABOUT ICU RESEARCH

Recommendation 13. Raise public awareness of ICU research, its purpose, the need for alternative consent processes, and that in some situations consent may not be sought from patients and/or family members until the emergency situation has passed (see Appendix 4, [Section 7](#), p. 35, line 15).

- Use public facing platforms, such as social media, posters, information leaflets, animations, videos to publicise:
 - That your hospital conducts research to help save and improve critically ill patients' lives. This might include publicising specific examples of published ICU research to help convey the message and their impact on clinical care.
- Within the ICU use patient and family member facing information such as posters, information leaflets, animations and videos to publicise:
 - Any studies being conducted on the ICU that might involve recruitment of patients without prior informed consent from patients and/or consent/consultation with family members. Briefly explain: study aims, inclusion criteria, why informed consent cannot be sought prospectively and advise patients and family members that they may be approached by a research nurse about a study. Provide details of where patients and family members can access further information (e.g. study recruiter name, photograph (where possible), contact details and/or links to study website).

- For any studies using personal data without explicit informed consent, include details of where patients and family members can access further information about the study (as described above).

SECTION 8: RAISING AWARENESS OF ICU RESEARCH AMONGST CLINICAL STAFF

Recommendation 14: Raise awareness of ICU research and consent processes (see Appendix 4, [Section 8](#), p. 36, line 2).

- Hospitals should consider providing clinical staff with access to research training or provide information (e.g. a research focussed newsletter) about ICU research and consent processes. The content should aim to:
 - Raise awareness of ethics and other review processes in place to help protect the rights, safety and well-being of research participants.
 - Introduce ongoing studies including an overview of associated consent processes, relevant information sheets, and FAQs for patients/family members. Convey messages about how previous studies have informed or improved clinical care in the ICU.
 - Provide contact details for key research team members should clinical staff have any queries regarding a study, or for them to signpost patients/family members if they have queries. This should include explicit clarification of who is responsible for obtaining consent, enrolling patients, updating notes etc.

SECTION 9: RECOMMENDATIONS FOR FURTHER RESEARCH

Perspectives is one of the first studies in the UK to look at stakeholder perceptions of recruitment and consent to ICU studies. As such, there are areas which need further exploration:

- Informing bereaved family members about a deceased patient's inclusion in a study. Further research is needed to inform the recommendation in section 5. Such research should include bereaved family members, particularly those who have experienced ICU research discussions. Such research could usefully be a basis for a consensus process to ascertain whether or not usual practice should be to inform bereaved family

members about a deceased patient's inclusion in a study, and if so, the most acceptable timing and ways of informing bereaved family members.

- Co-enrolment i.e. patient, family and research staff experience of the recruitment of ICU patients into more than one study.
- Consultation and consent to studies by phone and/or video calls.
- Research staff eliciting and addressing patient/family perceptions/misunderstandings of research during study discussions.
- Use of multi-media resources as part of study information provision in the context of ICU research to see if these facilitate patient/relative understanding.
- Improving awareness of ICU research and its importance among non-research staff to facilitate recruitment and satisfaction with the recruitment experience.
- Approaching patients (who have a planned admission to ICU) in outpatient clinics about research that they may become eligible for, to facilitate patient understanding and autonomy. This should also identify mechanisms to ensure that patients or their families are not re-approached at a later point if they decline.
- Review of time windows for patient recruitment in previous critical care studies that have used RWPC and acceptability/compliance with legal frameworks. Also the impact on scientific integrity, patient outcomes, recruitment etc.
- The use of collaborative discussions to assist family decision making about their relatives' participation in research in ICU research would benefit from further evaluation.

Appendices

Appendix 1: Summary of approaches to recruitment and consent seeking with incapacitated patients in England and Wales by study type (adapted from the Health Research Authority website and relevant legislation, 2013, 2018, 2019)

Clinical trials of investigational medicinal products (CTIMPs)

CTIMPs in non-emergency situations

Investigators can seek prospective consent from an incapacitated patient's legally designated personal representatives. Personal representatives are personally known to the patient, such as a family member or a close friend. However, if there is no representative, they are not available or they are unwilling to act (i.e. you can't contact them or they don't want to make that decision) a doctor who is independent of the study can act as a legally designated professional representative, and approve a patient's recruitment to a trial in certain circumstances. Researchers will usually seek consent (e.g. for continued participation and further disclosure of confidential information) from the patient, if and when they regain capacity.

CTIMPs in emergency situations

When investigating treatments that must be administered urgently and it is not reasonably practicable to obtain consent from a legally designated representative, patients can be recruited into a trial without prior consent. This is known as research without prior consent (RWPC). As patients recruited under this process may regain capacity to give consent, researchers are required to plan how they will involve patients in the on-going consent process. Trial participation and any relevant consent required (e.g. consent for continued participation and disclosure of confidential information) should be discussed with legally designated representative, or patient if they regain capacity, as soon as possible after the patient's recruitment to the trial.

Other study types

Other study types are those that involve the processing of personal data, administration of interviews or observations, and clinical trials that are not CTIMPs.

Other types of study in non-emergency situations

Before a patient is recruited to such a study, investigators are required to seek advice from the patient's personal consultee, usually a family member, about the patient's likely wishes. If investigators are unable to identify a personal consultee they can consult with a nominated consultee, which is usually a doctor responsible for the patient's care who has no connection to the research. When a patient recruited under a consultee process subsequently regains capacity, study participation should be discussed.

Other types of study in emergency situations

Patients can be recruited without prior advice from a consultee, provided it is not reasonably practicable to seek such advice in advance. Investigators need to seek agreement of a registered medical practitioner who is not involved in the organization or conduct of the study - unless there is insufficient time to obtain that agreement. The consultee's advice should be sought on the participant's likely views and feelings about the study as soon as possible after recruitment. If objections are raised, the patient must be withdrawn unless doing so would pose a risk to the participant's health. When a patient recruited under a consultee process subsequently regains capacity, study participation should be discussed.

For legal provisions for recruitment and consent of incapacitated patients in:

- Scotland see <http://www.hra-decisiontools.org.uk/consent/principles-ALC-Scotland.html>
- Northern Ireland see <http://www.hra-decisiontools.org.uk/consent/principles-ALC-NIreland.html>

Appendix 2: Outline of the methods of the Perspectives Study

PERSPECTIVES on Enhancing Consent and recruitment in Intensive care Studies (The Perspectives Study) was funded the ESRC. The Perspectives Study explored the views and experiences of patients, their family members, and healthcare practitioners regarding consent and recruitment procedures of studies that take place in the intensive care unit (ICU). The aim was to generate evidence to inform the development of this guidance document, to enhance recruitment and consent procedures in the critically ill. To achieve this, we used established social science methods and ethical analysis across three interrelated empirical work streams, which fed into the mixed methods and ethical analysis workstream on which this guidance is based.

In workstream (WS) 1, 17 ICU clinicians/researchers, and eight patient and public involvement (PPI) contributors with experience of working on ICU studies, took part in telephone interviews about the problems and potential solutions in recruitment and consent to ICU studies. This informed the development of the survey for WS2.

In WS2, 1453 participants from 14 ICUs in England took part in the survey, which explored experiences and views of ICU research recruitment and consent process. Forty four surveys were either duplicates or had substantial missing data so 1409 surveys were included in the analysis. Of these, 333 surveys were from ICU patients, 488 from family members (of whom 63 were bereaved) and 588 were from healthcare practitioners. Thirty five percent (115/333) of patient surveys and 32% (157/488) of family member surveys were from individuals who reported having been approached about research in the ICU, while 44% (260/588) of healthcare practitioner surveys were from those who indicated they had a role in research.

For WS3, a purposive sample of 60 participants, 54 of whom had completed the WS2 survey⁸, were interviewed in-depth to explore their survey responses and their wider perspectives on ICU research. This included 13 patients, 30 family members (of whom 4 were bereaved before completing the survey, and 5 were bereaved since they or another family member completed the survey), and 17 healthcare practitioners. Of interviewed patients and family members, 25 had been approached about a study while in the ICU. Of healthcare practitioners, 12 had research roles at the time of their interview (3 doctors, 7 research nurses and 2 pharmacists).

⁸ The six additional interviewees comprised: four family members of surveyed patients (where the family member had been present during the patient's ICU stay); two ICU patients whose family members had completed a survey. Although these six interviewees had not completed the WS2 survey, the protocol permitted interviews with such individuals if they had close ties to WS2 participants.

Appendix 3: The Perspectives Study Advisory Group

In alphabetical order:

Professor Stephen Brett, ICU researcher/clinician, Imperial College London and Imperial College Healthcare NHS Trust

Professor Angus Dawson, Biomedical ethicist, University of Sydney

Dr Steve Dilworth, PPI member

Dr Lucy Frith, Perspectives study co-investigator and biomedical ethicist, University of Liverpool

Professor Carrol Gamble, Perspectives study co-investigator and biomedical statistician, University of Liverpool

Ms Katie Neville, Quality Assurance Manager, Clinical Trials Research Centre (CTRC), University of Liverpool

Dr Katie Paddock, Perspectives study postdoctoral researcher and social scientist, University of Liverpool

Professor Natalie Pattison, Florence Nightingale Foundation Clinical Professor, University of Hertfordshire

Mr Mike Ross, PPI member

Professor Kathy Rowan, ICU researcher, Intensive Care National Audit and Research Centre (ICNARC)

Dr John Trinder, Chair of Advisory Group and ICU researcher/clinician, Ulster Hospital Belfast

Professor Tim Walsh, ICU researcher/clinician, University of Edinburgh and Edinburgh Royal Infirmary

Prof. Dr. med. Ingeborg Welters, Perspectives study co-investigator and ICU researcher/clinician, University of Liverpool and The Royal Liverpool University Hospital

Dr Kerry Woolfall, Perspectives study co-investigator and social scientist, University of Liverpool

Professor Bridget Young, Perspectives study lead investigator and social scientist, University of Liverpool

Appendix 4: Statements of key evidence considered when developing each recommendation

1 It is important to note that our main focus here is reporting stakeholders' perspectives, and
2 that some of these differed to current legal frameworks and regulation.

SECTION 1. PRE-RESEARCH ACTIVITY

4 In WS1 interviews, many researchers/clinicians acknowledged the importance of including
5 patient and public involvement contributors (PPI) in ICU studies. However, for most
6 researchers, consultation with PPI contributors had involved commenting on patient and family
7 study information materials rather than informing the design of recruitment and consent
8 processes. Some researchers indicated that the scope for PPI contributors to input to
9 recruitment and consent processes was limited due to the specialist medical and research
10 methods knowledge needed, or because recruitment and consent procedures were
11 determined by study aims, allowing little scope for discussion and feedback. None of the PPI
12 contributors described having provided any input to the design of recruitment and consent
13 processes. They explained that they were brought in only after funding was awarded, and/or
14 that their roles largely entailed attending study steering group meetings. While PPI contributors
15 were largely content with their roles, there are indications that delaying PPI until funding is
16 awarded and allocation of PPI roles that focus mainly on steering group attendance can limit
17 the opportunity for PPI contributors to inform the design of studies (Dudley et al., 2015).
18 Meaningful PPI is widely advocated, including by the National Institute of Health Research
19 (2019) and the Health Research Authority (Health Research Authority / INVOLVE, 2016 a&b).

20 Some researchers in WS1 indicated they had difficulties securing research ethics approval for
21 alternative consent procedures, such as professional consultation/consent, research without
22 prior consent, or obtaining consent over the phone. However, despite these difficulties, only a
23 few researchers commented on input from PPI contributors as being relevant to seeking ethics
24 approval. Those who did so noted that it had been helpful, while recent writings point to the
25 contributions that PPI can make to ICU research (Burns et al., 2018; Burns et al., 2017).

1 Very few patients or family members interviewed in WS3 who had been approached about a
2 study while in the ICU had kept the information sheets or knew where they were. Some
3 mentioned that they were given numerous pieces of paper while in the ICU – patients had
4 limited room to store these, and family members often misplaced them, unless it was a notably
5 important document. As a consequence during interviews they felt uncertain what studies the
6 patient had been approached about or recruited to. A few suggested that it would be helpful if
7 copies of information sheets could be emailed to patients and family members so they had a
8 record of their research activity. In addition, some suggested that using patient diaries to note
9 when a patient or family member had been approached about a study, and by whom, would
10 also help patients and their families to construct a clearer narrative of their time in the ICU.
11 While most interviewed patients and family members did not comment in detail on the clarity
12 of written study information materials, several practitioners noted that some of these
13 documents were lengthy and overly complex. We also note recently published work indicating
14 that many information materials for personal and professional consultees/representatives,
15 including those used in critical care studies (Shepherd et al., 2019; Atwere et al., 2018), do
16 not adhere to recommendations, with some lacking essential information as appropriate to the
17 specific roles of the different decision-makers involved.

18 Some practitioners, patients, and family members interviewed in WS3 also suggested the
19 benefit of raising awareness of ICU studies during scheduled outpatient appointments where
20 patients had a planned admission to ICU. This approach could increase the likelihood of a
21 patient making a decision about research for themselves, and reduce the need for alternative
22 consent procedures that may place pressure on family members. More broadly, interviewees
23 also suggested using posters, leaflets, multi-media resources and social media to publicise
24 research.

25 **SECTION 2. NON-EMERGENCY RESEARCH INVOLVING A PATIENT WHO HAS**
26 **CAPACITY**

27 Interviews during WS1 and WS3 indicated that patients, family, and healthcare practitioners
28 were in agreement that consent should ideally be sought from the patient when possible, which
29 is consistent with legal frameworks and with the principle of respect for patient autonomy
30 (Beauchamp & Childress, 2001). However, all stakeholder groups recognised that seeking

1 consent is a complex process in ICU studies and that patients are often not physically or
2 emotionally in a position to discuss research.

3 **SECTION 3. NON-EMERGENCY RESEARCH WITH A PATIENT WHO LACKS CAPACITY**
4 **AT THE POINT OF RECRUITMENT**

5 **Personal consultee or consent processes**

6 WS2 survey responses indicated that when a patient is too ill and lacked capacity to consent
7 for themselves, most patients (68%) family members (83%) and practitioners (76%)
8 considered it acceptable for a family member to decide about research participation on behalf
9 of incapacitated patients. This suggests that the personal consultee/consent process currently
10 used in ICU studies is supported by stakeholders and is broadly consistent with work on the
11 concept of relational autonomy in clinical care and research (Gillies & Entwistle, 2012).

12 When interviewed in WS3 about research decision-making, family members described
13 considering both whether the patient themselves would want to take part in research and
14 weighing up the risks and benefits of the study on behalf of the patient. When patients and
15 family members considered the acceptability of different consent procedures, many pointed to
16 factors such as the level of risk or invasiveness of a study, or the risk that a study's procedures
17 (e.g. venepuncture) might cause discomfort to a patient. The greater the perceived risk or
18 discomfort of a research study to a patient, the more involved family members felt they should
19 be in the decision.

20 Patients and family members also expressed some confusion as to the distinction between
21 care and research – with some family members making little distinction between decisions
22 about treatment and decisions about research. This resembles the therapeutic misconception,
23 which has long been reported and debated in research (Appelbaum et al, 2004; Appelbaum
24 et al., 1987). Practitioners we interviewed were aware that such confusion could complicate
25 the consent/consultation process and they talked about how they tried to address it. Some
26 patients and family members noted that the distinction between research activities and non-
27 research (clinical) healthcare activities could be made clearer if research practitioners in the
28 ICU had either identifying badges or a different uniform to the clinical healthcare practitioners.
29 However, other patients and family members had noticed the different colour uniforms, but
30 they were unsure what the different colours meant. While distinctions between treatment and
31 research were sometimes hard for patients and family members to take on board, both groups

1 expressed altruistic motivations for their participation in ICU research, and/or their willingness
2 to participate in the future.

3 When asked in WS3 interviews about personal consultee/consent processes, patients,
4 families, and practitioners, commented that this was acceptable to them because family
5 members or close friends would know the patient well, and know their likely feelings about
6 being involved in research and/or would want to “protect” the patient’s best interests. Patients
7 and family members trusted one another to make the “right” decision. Previous research
8 involving hypothetical scenarios indicates that family members are often inaccurate in their
9 predictions of patients’ preferences regarding research participation (Ciroidi et al., 2007;
10 Coppolino & Ackerson, 2001; Newman et al., 2012). However, a systematic review comparing
11 the accuracy of family members and doctors regarding patients’ treatment preferences, again
12 in hypothetical scenarios, indicated that family members tend to be more accurate than
13 doctors (Shalowitz et al., 2006). Moreover, many family members interviewed in WS3 of the
14 Perspectives study emphasised the importance of feeling involved in decisions relating to the
15 patient.

16 In situations where multiple family members were present during the research
17 consent/consultation process, most participants acknowledged that the decision was
18 ultimately a process that was shared among family members, rather than based on the
19 unilateral decision of a single family member, and should be approached as such by
20 healthcare practitioners. While stakeholders felt personal consultee/consent processes were
21 acceptable, they nonetheless thought it important for patients to be informed of any decisions
22 about research made on their behalf as soon as practicable. If possible, the patient should
23 then have final say in either their continuation in the study or the use of the data. When being
24 approached about research after they have recovered, patients advised that they welcomed
25 healthcare practitioners being sensitive to what they had been through. Simple
26 acknowledgements would often suffice, although adjustments such as seeking verbal consent
27 from patients who might struggle to physically sign a consent form would be welcome.

28 At interview, some family members initially did not understand why they were, or might be
29 approached about research relatively soon after the patient arrives in the ICU, and
30 emphasised the need to give family members time to adjust and learn more about the patient’s
31 condition. Once explored further, family members appreciated the necessity of an early
32 approach about research, and recommended that research staff explain to family members
33 *why* they were being approached at what might appear to be an insensitive time.

1 Noting that most patients and family members had little experience of research and medicine,
2 some interviewed practitioners, patients, and family members felt that personal
3 consultee/consent processes were burdensome for family members. Some practitioners also
4 argued that patients and family members can never give truly informed consent, as they would
5 ultimately require medical qualifications and experience to appreciate all the risks and benefits
6 of each study. Though some patients and family members agreed with this, nonetheless, they
7 were clear that they should be involved in decisions about research involvement (Tutton et al.,
8 2018).

9 WS3 interviews with patients, family members and practitioners pointed to a few instances
10 when pronounced misunderstandings had arisen regarding aspects of a research study. Some
11 of these misunderstanding could be regarded as 'injurious misconceptions' (Snowdon et al.,
12 2007), in which patients or families believed a study could lead to harm. These could
13 potentially be ameliorated by sensitively exploring patients' and families' understanding of a
14 study during collaborative discussions about research (Donovan et al., 2016). Such
15 exploration is consistent with principles of relational autonomy (Gillies & Entwistle, 2012).

16 **Use of telephones for personal consultee or consent processes**

17 WS2 survey responses indicated that when a patient is too ill to decide for themselves, most
18 patients (64%) family members (76%) and practitioners (59%) considered it to be acceptable
19 for a doctor to ask a family member over the telephone for an opinion on whether the patient
20 should be included in a research study. However, WS3 interviews suggested that opinions on
21 the use of phones were mixed. Some participants were in favour of obtaining consent over the
22 phone when the alternative was professional consent, as this ensured that the decision
23 remained with family members. Other participants criticised this approach because staff are
24 unable to gauge body language to tailor their approach to the family members, and because
25 receiving a telephone call while a relative is in the ICU can be distressing. Many of these
26 participants argued that phone calls should only be used when there is a tight time frame
27 and/or the family members are not physically able to go to the hospital to provide consent, and
28 failing to obtain consent would jeopardise the study.

1 **Professional consultee or consent processes**

2 Several questions in the WS2 survey asked about doctors consenting to research on behalf
3 of incapacitated patients in different situations. These questions did not refer to the
4 requirement for such doctors to be independent of the study, as piloting of the survey indicated
5 that this information had led to confusion among some patients and family members.
6 Responses to the survey questions indicated that most stakeholders supported doctors
7 consenting to research on behalf of incapacitated patients in situations where there were no
8 known family members (patients 60%, family members, 63% practitioners 63%) or if time was
9 too short to contact family members (patients 57%, family members, 51%, practitioners 53%).
10 Most patients (55%) and family members (52%) also supported consent by doctors when
11 family members were unavailable, compared to 45% of practitioners who supported this. We
12 acknowledge that interpretation and comparison of responses for the different stakeholder
13 groups may be clouded by the survey questions having omitted that doctors consenting on
14 behalf of patients will be independent of the study. Nevertheless, this pattern of responses
15 suggests that the professional consultee/consent process is supported by the majority of
16 stakeholders for most situations. We also note that in all three stakeholder groups,
17 approximately 25% of survey respondents did not agree with doctor consent for ICU studies
18 whatever the situation. It is possible that these proportions would have been lower had the
19 survey questions referred to the requirement for doctors consenting for patients to be
20 independent of the study.

21 WS3 interviews enabled us to further explore the views of stakeholders regarding doctor
22 consent, including the views of a small subset of respondents who expressed disagreement
23 with doctor consent in their surveys. We found that they were more flexible towards doctors
24 consenting to research on behalf of incapacitated patients than their survey responses had
25 suggested. Most patients and family interviewees, and some practitioners, shifted markedly in
26 their views of doctor consent when the particularities of a study and situation could be
27 explained and explored in more depth (Table 1, page 39). Importantly, interviews also allowed
28 us to explain that the doctor providing consent on behalf of a patient would be independent of
29 the study. Knowing this seemed to reassure most patients and family members, although as
30 we note later, doctor independence was not important for some interviewees.

31 Previous work by the HRA/others suggests that the public's default idea of research is often
32 that it involves testing an experimental medicine, and these ideas of research were also
33 evident in the Perspectives interviews with those who had little previous contact with research.
34 Therefore, it may have been that survey respondents were approaching the questions with

1 this default idea of research in mind and hence the shift we saw in the interviews when other
2 types of research were raised and discussed. Interviewees also indicated that they disliked
3 the removal of control or decision-making involvement from those who know the patient best
4 – their family members. Nevertheless, they understood the necessity of professional
5 consultee/consent processes in the ICU. Ultimately, participants agreed that all effort should
6 be made to contact family members before using professional consultee/consent processes,
7 and that family members should be contacted as soon as possible if these processes have
8 been used. Patients and family members also felt it important to explain the rationale for using
9 professional consent/consultation when later discussing the research with family members or
10 seeking consent from patients.

11 In WS3 interviews, practitioners who had a research role were more accepting of doctor
12 consent than practitioners with no research role. Practitioners with no research role expressed
13 similar concerns as patients and family members, regarding the potential negative impact of
14 research on a patient's recovery, and removing decision-making involvement from family
15 members who might know the patient's feelings towards research. This difference between
16 practitioners may be linked to those with research roles already knowing that doctors who
17 consent to studies on behalf of patients are independent of the study.

18 As noted above, in the WS3 interviews it was possible to explain that doctors who consent to
19 studies on behalf of patients are independent of the research. When asked about this, most
20 stakeholders believed such independence was important to avoid any bias or perception of
21 bias when recruiting patients to studies. However, some patients and family members did not
22 feel that a doctor needed to be independent from the study, and as such, their views were
23 different to current legal frameworks, which stipulate the need for independence. These
24 interviewees explained that they trusted doctors would always act in the patient's best
25 interests, which is consistent with other findings (Tutton et al., 2018). Some even saw
26 advantages in a doctor being a member of the research team; patients and family members
27 felt such doctors would have a detailed knowledge of the study which would be helpful in their
28 professional consultee/consent role, though again such views are inconsistent with the
29 requirement for independence in current legal frameworks.

30 As noted above, WS3 interviewees often shifted markedly in their views of professional
31 consultation/consent depending on particularities of the study. For example, some thought
32 professional consultation/consent was acceptable if a study had low or no impact on the
33 patient – particularly observational studies, or studies with procedures that could be completed
34 as part of standard care (e.g. blood tests, scans). Interviewees tended to disagree with

1 professional consultation/consent being used when the research involves something “extra”
2 or overwhelmingly “different” to standard care. Table 1 below summarises their views and how
3 these shifted depending on the nature of a study.

4 In WS1 interviews, researchers spoke about situations where there was uncertainty about
5 whether to use a professional consultee/consent or a personal consultee/consent. Most drew
6 a clear distinction between professional versus personal consultee/consent, in keeping with
7 current regulatory frameworks. However, a few researchers described a more blended or
8 collaborate approach, whereby under certain circumstances (e.g. a patient’s family lived some
9 distance away), researchers would contact family members in advance of a patient’s
10 recruitment to inform them of a plan to recruit the patient to a study under a professional
11 consultee process and seek the family’s views on this.

12 **Seeking consent from patients recruited under personal consultee or professional** 13 **consent processes**

14 Some patients stated that they felt they had been approached about a research study when
15 they were still finding it difficult to take in information and possibly still lacked capacity to make
16 an informed decision. There are indications that multimedia resources e.g. animations and
17 videos can be helpful in supporting information provision in non ICU studies (Kraft et al., 2017;
18 Tait & Voepel-Lewis, 2015). Such resources could be useful in ICU studies too, at least in
19 supplementing written information leaflets.

20 **SECTION 4. ADDITIONAL CONSIDERATIONS FOR EMERGENCY RESEARCH WITH A** 21 **PATIENT WHO LACKS CAPACITY**

22 We explored stakeholders’ views about research without prior consent (RWPC) in the WS3
23 interviews, but not in the survey as we felt the topic was a difficult one to explore in a survey
24 and we wanted to avoid adding to its length and complexity. Many patients and family
25 members were initially unsure of the concept of RWPC. Analysis suggested they initially
26 tended to see research as a non-urgent activity and struggled to imagine a scenario when (in
27 order for a study of a treatment to be valid), research activity had to commence immediately
28 and there would be no time to approach anyone for consent/consultation. When the
29 interviewer provided examples that illustrated why a treatment being researched needed to
30 be given straight away, most patients and family members understood the need for this

1 consent process, although some remained confused. For example, they expressed concern
2 over the possibility that patients could be allocated to a less effective treatment. This illustrates
3 the importance of explaining clinical equipoise in this situation. More broadly, it also points to
4 the value of raising awareness that trials comparing treatments are only conducted when it is
5 agreed that it is uncertain which treatment is most effective. When RWPC is used patients and
6 family emphasised the importance of subsequently informing patients and family members
7 that the patient had been included in a study and seeking consent from the patient as soon as
8 practicable (Woolfall, et al., 2015).

9 **SECTION 5. DISCUSSING ICU RESEARCH WHEN A PATIENT HAS DIED**

10 A patient who is enrolled in a study under an emergency or professional consent/consultee
11 process may sadly die before the study is discussed with the family. An important question is
12 whether a family should subsequently be told about the deceased patient's inclusion in the
13 study. This is an emotive issue and we were only able to explore practitioner views about it in
14 WS1 and WS3, and with a minority of patient and family interviewees (N=10) in WS3. In
15 discussing this scenario, we explained that we were referring to situations in which there was
16 no indication that a study had an influence on the patient's death.

17 All participants acknowledged that this was an ethically complex situation, with several
18 commenting on the dilemma it posed - informing family members could cause distress and
19 confusion, whereas not doing so was inconsistent with the principle of openness and
20 transparency. Practitioner interviewees indicated that sites varied in how they managed this
21 situation, but most said that following a bereavement it was not usual practice to inform
22 families of a patient's recruitment to a study. They often explained that this was to avoid
23 causing families undue distress. While patient and family member interviewees agreed that
24 hearing the news that a deceased loved one had been recruited to a study would be
25 distressing, most were clear they would want to be told. Several spoke about the importance
26 of openness in matters relating to the deceased patient and indicated that this outweighed
27 other considerations. Some wanted discussions to include an explanation of why the research
28 was needed and why they had not been informed around the time the patient was recruited.
29 They added that they would want to be informed soon after the patient had died, but not
30 necessarily immediately afterwards. These findings echo those from recent research with
31 bereaved parents in paediatric critical care studies). Of the 22 bereaved parents interviewed
32 across four studies (Inwald et al., 2018; O'Hara et al., 2017; Peters et al., 2019; Woolfall et al.,

1 2015; Woolfall et al., 2014), all were clear that they would want to be told that their child had
2 taken part in a research study, while acknowledging wide differences in how people respond
3 to grief and that communication needs to be personalised to the people and circumstances
4 involved.

5 **SECTION 6: DISSEMINATION OF STUDY FINDINGS TO PATIENTS AND FAMILY**
6 **MEMBERS**

7 Some patients and families who had been involved in research, either in the ICU or elsewhere,
8 commented in their WS3 interviews that participants are often not told about the findings of
9 studies. This left them feeling disappointed. They emphasised that they would welcome the
10 opportunity to hear about the outcomes of studies that they had contributed to and about how
11 the study had achieved its aims or improved care. However, many studies will take several
12 years for the findings to become available. As such, there will often be a need to manage
13 patients' and families' expectations about the communication of study results.

14

15 **SECTION 7: RAISING PUBLIC AWARENESS ABOUT ICU RESEARCH**

16 Several patients and family member interviewees in WS3 described their initial surprise at
17 learning that research occurred in the ICU. They attributed this surprise to an instinctive sense
18 that ICU patients were 'too ill' to be exposed to research. However, they explained that they
19 had previously given the matter little consideration, and having done so, could understand the
20 need for research to improve the care of ICU patients.

21 Mirroring these findings from patient and family interviewees, some practitioners interviewed
22 in WS1 and WS3 suggested that research in the ICU would benefit from better 'marketing' to
23 patients and families, to improve visibility of research in the ICU, and to negate any
24 misunderstandings. All stakeholders agreed that information about the ICU research could be
25 made more prominent and accessible, including examples of how research has
26 improved/informed care, and any ongoing ICU studies (Anderson et al., 2017).

SECTION 8: RAISING AWARENESS OF ICU RESEARCH AMONGST CLINICAL STAFF

Practitioner interviewees in WS3 pointed to a disconnection between research staff and their colleagues who had exclusively clinical roles (e.g. bedside nurses). Many commented that research teams attempted to update non-research colleagues about studies, but research meetings sometimes took place at inconvenient times, or outdated information sheets were left in communal areas. Interviews and surveys suggested that some non-research healthcare practitioners held similar concerns or misunderstandings as patients and family members, including concerns about patient safety and autonomy. Patients and family members often spoke to bedside nurses about studies, and it was apparent that if these healthcare practitioners do not understand a project adequately, they will be unable to advise or discuss the project adequately. Bedside nurses are also important in providing moral and practical support for research staff engaged in recruitment and consent activities.

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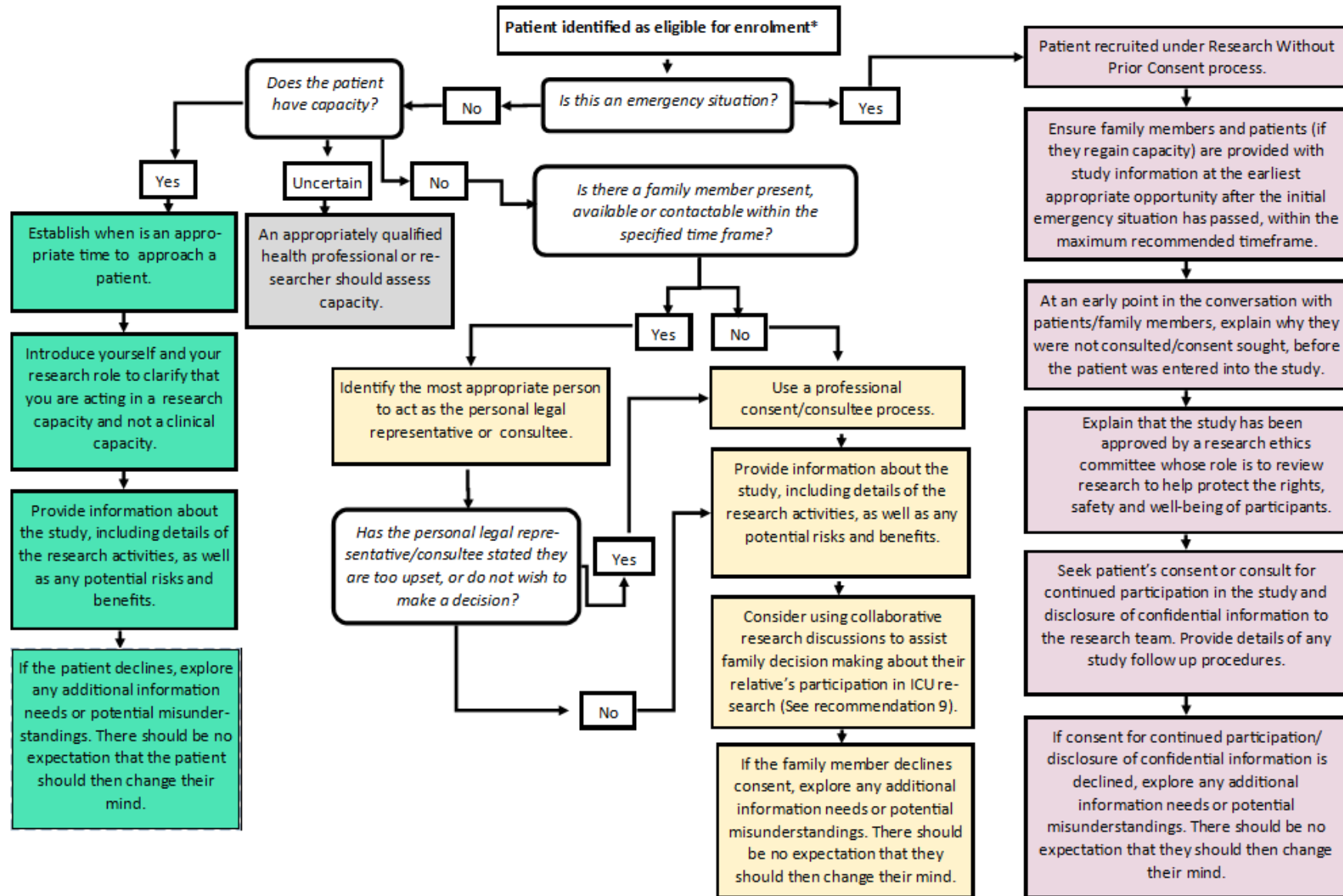
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Table 1. Summary of the acceptability of professional consultation/consent to patients and families and how their views shifted depending on study characteristics.

- **Just data.** No additional procedures, scans, swabs, etc. → Professional consultation is acceptable. *Some even suggest that it is acceptable for studies to proceed without professional consultation.*
- **Taking research samples from ‘left over’ samples collected as part of standard care.** E.g. A 15ml blood sample taken for standard care purposes and 5/10ml of this is used for research → Professional consent is acceptable. *Some even suggest that it is acceptable for studies to proceed without professional consultation.*
- **Taking additional samples for research.** E.g. 15ml blood sample taken for standard care purposes + 15ml for research purposes with both taken during a single procedure → Family members should be consulted. *Concerns that ICU patients “need all their blood to survive”. But, some patients/family members would be accepting of professional consultation here, as this scenario differed little to standard care.*
- **A different type of standard care.** E.g. hospital A gives 45ml of standard care drug X whereas hospital B gives 50ml: study is to determine which dose is more effective → Family members should be consulted where possible, but professional consultation/consent would be acceptable as these drugs are still standard care. But family members should subsequently be consulted ASAP.
- **An additional procedure/sample that is not part of standard care** E.g. No blood required for standard care procedures, but blood sample required for research → Family members should be consulted. *Could require additional access to a line/ new line in /additional venepuncture which could hurt. Don’t want to rock the boat.*

The overall concern of patients and family was the potential impact of the research on a patient’s recovery. They viewed “researched areas” as unknowns and were therefore wary of the potential impact on patients. Anything beyond “standard care” would require consideration from family members where possible.

Figure1: Flow chart of decision points in recruitment and consent to critical care studies



* Consent processes should be consistent with those described in the study protocol that has been approved by a research ethics committee