



January 22, 2015

The Office for Human Research Protections
Department of Health and Human Services
1101 Wootton Parkway, Suite 200
Rockville, Maryland 20852

RE: Comments on Draft Guidance on Disclosing Reasonably Foreseeable Risks in Research Evaluating Standards of Care

AcademyHealth is pleased to submit feedback to the Office for Human Research Protections (OHRP) on its Draft Guidance on Disclosing Reasonably Foreseeable Risks in Research Evaluating Standards of Care.¹ We represent the interests of more than 5,000 scientists and policy experts and 180 organizations that produce and use health services research to improve our nation's health and the performance of the health care and public health systems. Their work, largely funded by the federal government, has helped us understand and improve our complex health system, and enable better health outcomes for more people at greater value. As such, we are well-positioned to comment on the draft guidance, as many of our members are engaged in research evaluating standards of care.

Recommendation

As currently written the guidelines will have a profound negative effect on our ability to develop critically needed knowledge, and may also discourage patients from enrolling in studies that will provide them with more information on risks and benefits than they currently receive as part of routine care. Because of the complexity of these issues, and important ongoing empirical research that will clarify public attitudes on consent in this type of research, we recommend that OHRP take no further action on this draft guidance, and develop a new draft after there has been more opportunity to publicly analyze and debate these issues.

Rationale

Despite decades of medical research, we still lack high quality evidence to support a majority of clinical decisions that patients and clinicians face. This is especially true in determining the relative benefits and risks for subsets of the population. As a result, millions of individuals receive suboptimal care, despite clinicians' efforts to develop

¹ These comments were prepared by a working group of leading AcademyHealth members who are experts in the field of health services research, representing delivery systems, academia, think tanks, and policy institutes, and were approved by representatives of AcademyHealth's Committee on Advocacy and Public Policy and Board of Directors.

consensus guidelines and interpret and implement them in the best interests of patients. One important way to address these challenges is the conduct of studies that are embedded in normal clinical research settings, involving patients who are representative of the intended target population. Yet it is precisely these kinds of studies that will be most jeopardized by the proposed OHRP guidance.

Health care delivery organizations have explicit legal and regulatory requirements to monitor and manage care delivery systems in order to maximize performance and outcomes via quality assurance (QA) and quality improvement (QI). We are aware that HIPAA regulations identify both QA and QI activities as part of health care operations and that oversight agencies, such as the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission require that care delivery groups put in place both QA and QI systems with the aim of supporting the reliable implementation of best care. We believe these activities should be performed in a manner that maximizes the information they yield. Sometimes purely observational assessments are appropriate. In other circumstances, randomization will yield much more information, while adding little or no additional cost or risk. This is particularly true of system level changes in formularies, treatment protocols, staffing levels, implementation strategies, and many other changes that are typically introduced without direct consultation with patients or most clinicians.

This expectation that QA/QI activities be performed to a high standard means the distinction between clinical research and clinical practice have blurred. (“Best Care at Lower Cost,” 2012). Interest and ability to conduct comparative effectiveness research and continuous QI in integrated delivery systems and across multicenter collaboratives did not exist at the time that current federal regulations governing human subject research were established (Selker, Grossman et al., 2011). Importantly, as stated by Kass et al., “Requiring that all activities that are designed to produce generalizable knowledge and that collect data systematically must undergo prior review by an ethics committee, even when patients’ clinical care is in no respect changed, is a misplaced moral criterion of what needs review and is a deep weakness in our current system (Kass, Faden et al., 2013, page S11).”

Recommended Principles for Consideration in New Guidance

The need to effectively communicate both benefit and risk to patients in treatment or for those involved in a research study is important. The draft OHRP guidelines call for improved communication about both *foreseeable risk* and *randomization*. However, we know that the informed consent process is flawed, and caution that over-disclosure can lead to non-disclosure due to the complexity of legal language and amount of information shared. Therefore, AcademyHealth urges OHRP to consider the following key issues in any revised guidance on research evaluating standards of care:

1. **Patients have the right to make their own decisions about their treatment options based on known potential, foreseeable risk and benefits, and their own preferences-- regardless of their participation in a research study.**

- The obligation to inform patients is similar whether they are being randomized for options within standard of care or if a clinician is explaining treatment options. The test for whether individual consent is needed should be: what does the median physician discuss with patients about care? This question can and should be answered empirically, by determining what clinicians and their patients actually discuss. We reject the notion that clinicians should explain less in non-randomized settings. Holding structured development of new knowledge to a standard that is much higher than that used in conventional practice holds back needed research without compensatory benefit to either the patient or future improvement in medical practice.

2. **We should not rely on a sole criterion of type of study design, such as randomized study designs, to create an oversight paradigm determining the intensity of oversight.**

There are some randomized studies that pose no difference in risks to participants than non-randomized studies or routine clinical care. The fact that study participants/sites are randomly assigned should not be an absolute requirement for a high level of oversight.

- Additionally, distinguishing between types of randomization as the current draft Guidance does will create a discrepancy between individual and cluster randomization (see text box). When the purpose is to implement best care using a pilot and deploy strategy, the differentiation should be made based on whether or not the services being studied are within the scope of usual standard of care, as described in the Hastings Center Report (Lynn, Baily & Bottrell, 2007). This may increase the responsibility of clinicians to provide adequate information about risks and uncertainties in clinical practice and not

Does Randomization Matter?

If a 100 hospital chain decides to roll out a new ventilator care bundle over 2 years that would not require consent. Should it matter if the order in which hospitals are introduced to the new practice is chosen randomly? Doing so would substantially increase the information available about risks and benefits of the new bundle, both to the chain and to the community at large. Does randomization (vs. any other sequencing) increase risks to anyone? Does it impose different oversight or consent requirements?

If a pharmacy purchasing consortium might choose on the basis of price or other commercial considerations between similar agents (e.g., thiazides, beta-blockers, etc.) as the default formulary preparation, would it also be possible for the consortium to contract for thiazideA at half its sites and thiazideB at the other half? Would it matter if the selection is made by randomization?

creating an unfair burden on clinicians who are actually trying to help bring care closer to the accepted standards of care and to reduce unwarranted and arbitrary variation in care.

- Requiring patient-level, written informed consent for cluster RCTs of practices and treatments that are typically not decided by either the patient or the patient's provider, would make it impossible to conduct many important evaluations of practices and interventions already in use or that are otherwise simply be adopted without any ability to understand their impact on care and patient outcomes.

We believe it is critically important to facilitate research on care delivery and not further impede advancements in discovery. This principle should be the beacon against which all future revisions to this guidance are measured.

AcademyHealth and our members look forward to working with OHRP on future iterations of this guidance.

If you have questions about these comments, please don't hesitate to contact Dr. Lisa Simpson, President & CEO of AcademyHealth, at 202.292.6747 or at lisa.simpson@academyhealth.org.

References

"Best Care at Lower Cost: The Path to Continuously Learning Health Care in America," Institute of Medicine, 2012.

Grady, C. "Quality Improvement and Ethical Oversight," *Annals of Internal Medicine*, 146(9):680-681, 2007.

Kass, NE, RR Faden, SN Goodman, P Pronovost, S Tunis, TL Beauchamp. "The Research-Treatment Distinction: A Problematic Approach for Determining Which Activities Should Have Ethical Oversight," in Special Report: Ethical Oversight of Learning Health Care Systems, *The Hastings Center* (43(1):S4-S15, 2013.

Lynn, J. MA Baily, M Bottrell: *The Ethics of Using Quality Improvement Methods in Health Care*, *Annals of Internal Medicine*, 146:666-673, 2007.

Sacks, CA and EW Celestine. "Foreseeable Risks? Informed Consent for Studies within the Standard of Care.

Selker H, Grossmann C, Adams A, Goldmann D, Dezii C, Meyer G, Roger V, Savitz L, Platt R. "The Common Rule and Continuous Improvement in Health Care: a Learning Health System Perspective." *Institute of Medicine Discussion Paper*. Washington, DC: National Academies Press. 2011.