Ethics review of multisite studies: the difficult case of community-based Indigenous health research

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ABSTRACT

- Researchers have longstanding concerns about the logistical and administrative burdens posed by ethics review of multisite studies involving human participants.
- Centralised ethics review, in which approval by one committee has authority across multiple sites, is widely touted as a strategy for streamlining the process. The Harmonisation of Multi-centre Ethical Review (HoMER) project is currently developing such a system for Australia.
- It is unclear how centralised review will work for multisite Indigenous health research, where the views of local stakeholders are important and community consultation is mandatory.
- Our recent experience in conducting the National Indigenous Eye Health Survey (NIEHS) shows how elaborate the current ethics approval and community consultation processes can be, and points to several lessons and ideas to guide pending reforms.

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Ethics review of multisite studies involving human participants has long been a challenge for researchers in Australia[1-3] and overseas.[4,5] During the past decade, a series of reports, primarily from the United States[6-13] and United Kingdom,[14-16] have documented negative experiences with repeated reviews of the same study by ethics committees at multiple sites. Researchers' concerns include cost, inefficiency, tardiness, duplication, and the variable and inconsistent nature of ethical concerns identified across committees.

Following the UK's lead in this area, Australia is moving to address the problem by introducing procedures for a single locus of review for multisite studies that would have authority across all or most sites.[17,18] Centralised ethics review is a logical strategy for bringing efficiencies to the oversight of multisite studies. It is relatively easy to envision how this approach will work for some types of research — for example, a clinical trial recruiting patients at tertiary care hospitals in several states. For other types of research, it is less clear. In community-based population health research, for example, moves towards centralisation will force difficult trade-offs that could limit the role of local concerns and community input in the review process.

Multisite Indigenous health research looms as a particularly vexing challenge. Current national ethics guidelines stress the need to scrutinise researchers' engagement with Indigenous communities; the regulatory goal is to ensure that the design and conduct of the research is sensitive to the interests and concerns of those communities[19] (although there remains considerable debate and controversy regarding how best to achieve effective engagement[20-23]). Centralisation of ethics review of multisite studies will not displace those responsibilities. Hence, the burdens and barriers imposed by ethics review of multisite Indigenous health research could remain substantial.

Our recent experience during the National Indigenous Eye Health Survey (NIEHS) shows this mixture of forces at work. Here, we describe the course of ethics review and community engagement associated with the NIEHS. We also discuss pending reforms in the oversight of multisite studies and, reflecting on our experience, outline several ideas to guide policy reforms aimed at achieving sound ethics oversight of multisite Indigenous health research.

Case study: the NIEHS ethics review and community consultation experience

The NIEHS is a multistage randomised cluster study. It was designed to assess the prevalence and principle causes of vision impairment, the utilisation of eye care services, the barriers to eye health, and the impact of vision impairment among Indigenous Australians. The study methods are summarised in Box 1 and described in detail elsewhere.[24]

To conduct the NIEHS, we sought ethics approval and engaged in community consultation in all Australian states and territories during 2007 and 2008. Written correspondence relating to these activities was reviewed and analysed (Box 1). An overview of the process of ethics review and consultation for the NIEHS is provided in Box 2. A summary of the NIEHS ethics review experience is described in Box 3 and issues raised during the ethics review are categorised in Box 4.

Before the NIEHS could proceed, it was necessary to work through an elaborate process of ethics review and community consultation. This involved correspondence with 73 entities (Box 2). Only eight of the entities were Human Research Ethics Committees (HRECs) with formal approval authority, but those HRECs operated as gateways to 31 separate community organisations whose sign-off was essentially a pre-condition to ethics approval. The 39 entities with approval authority raised a total of 80 discrete ethics-related issues (Box 4).

As the NIEHS is a relatively large and fully funded project, it was possible to channel staff effort and project resources to manage the ethics review and consultation requirements. We did not formally track that level of effort, and quantifying it retrospectively is unscientific, but we estimate that over 22 months the effort absorbed 50% of one full-time staff member's time and 15% of each of the three chief investigators' time. Researchers pursuing smaller multisite studies, and those without full funding support, are likely to struggle to negotiate an ethics review process on this scale.

Pending policy reform: centralised ethics review

Centralised ethics review is a widely discussed policy reform for improving the efficiency of multisite research. The UK has moved aggressively in this direction.[25] Specially constituted committees within National Health Service trusts are empowered to confer approvals that operate throughout the UK. Although this reform does not appear to have eliminated the workload associated with

1 Analysis of the ethics review and community consultation processes associated with the National Indigenous Eye Health Survey (NIEHS)

The NIEHS

- The NIEHS involved a representative sample of 3000 Indigenous adults and children from 30 sites in all Australian states and territories.
- Participants completed a questionnaire on access to and utilisation of eye health services, and then underwent standard eye tests; participants with visual impairment then completed a questionnaire on quality of life.
- Data were collected between February and December 2008.

Ethics review and community consultation process

- During the planning stages, NIEHS investigators approached state and territory departments of health and Aboriginal community-controlled health organisations to seek advice on where to obtain appropriate ethics approvals to cover study activities in each state and territory.
- Appropriate community, state and federal entities to consult with were identified by seeking advice from a variety of sources (eg, ethics committees, community leaders in the study site areas, investigators' contacts).
- Efforts to secure ethics approval and community consultation activities began in February 2007 and were completed in December 2008.

Analysis of ethics review experience

- Written correspondence for seeking ethics approval was reviewed to construct two inventories: a list of corresponding entities by state and territory, and a summary of issues raised by each entity.
- An "issue" was defined as a query, concern or request that required a response from the NIEHS team; responses to some issues required alterations to the study protocol. In some cases, it was unclear whether matters raised constituted a discrete issue or formed a part of another issue; this was resolved by investigator consensus.
- Two of us (T M V and D M S) independently generated a set of issue types, based on a list of the issues raised and standard items covered in ethics review (eg, site selection, recruitment, participant information and consent forms, questionnaire design, risks and benefits). The two typologies were then compared, a final set of 18 types was determined, and the issues were categorised accordingly. ◆

gaining approval from local ethics committees, early reports suggest that it has streamlined overall approval processes markedly.[26-28]

Similar reforms are pending in Australia. Under direction from the Australian Health Ministers' Advisory Council, the National Health and Medical Research Council (NHMRC) established the Harmonisation of Multi-centre Ethical Review (HoMER) project during early 2007. This project involves development of a nationally harmonised system in which a single ethics and scientific review by an approved committee will cover multiple institutions, within and across states and territories.[18] New South Wales and Queensland already operate intrastate versions of such a system, and Victoria is currently developing one.

Challenge: managing a difficult balancing act

It is unclear how centralised ethics review will operate in the context of community-based studies, like the NIEHS, in which there are many local stakeholders. Centralisation will not change the desire of those stakeholders to have a say in how research is done in their communities, nor should it. Community organisations bring an important perspective — which an expert group focused on scientific issues and the requirements set forth in the *National statement on ethical conduct in human research*[29] will not have — and the ethics review process is deficient without this perspective.[30] In addition, effective community engagement enables effective implementation of research findings.

On the other hand, many layers of ethics approval and consultation almost certainly deter or derail large-scale investigation and surveillance in areas of national importance, such as Indigenous health.[31] If our experience with the NIEHS is a reliable guide, the administrative and logistical burdens of such ethics review are substantial. From a population health standpoint, this is an unfortunate outcome. Efforts to "close the gap" in the health of Aboriginal and Torres Strait Islander peoples depend on rigorous clinical and epidemiological research, some of it at the national level. Large-scale studies, arguably more than their small-scale counterparts, have the potential to produce the paradigm shifts in knowledge, public opinion and political will that are needed to make major strides towards improving Indigenous health.

How can this tension be addressed? Namely, how should regulators manage the apparently unavoidable trade-off between the desirability of ethics review that takes into account a variety of perspectives (including local community views and values) and the practical burdens and barriers created by subjecting multisite studies to multiple ethics reviews?

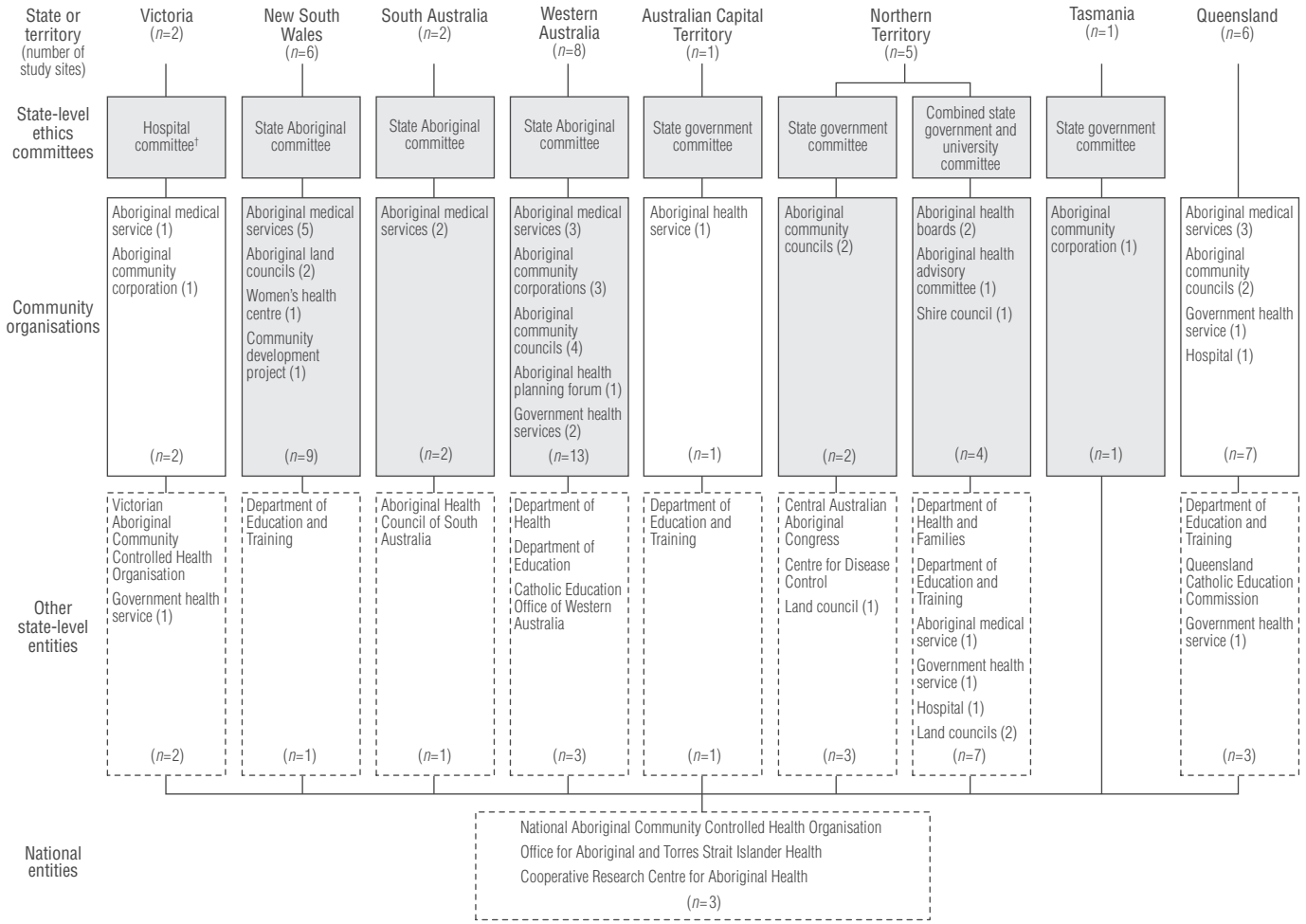
Insights: ideas to guide policy reform

Our experience sheds light on the tension but provides no simple answers. Nonetheless, it throws up several insights and ideas that may help to inform the HoMER project team as it tackles the challenge of streamlining ethics review in the context of multisite Indigenous health research.

First, the HoMER project is a welcome initiative. Although centralisation of the formal ethics and scientific review processes will be an incomplete solution for many types of multisite studies, it should help. If implemented effectively, a harmonised system will reduce barriers for all types of multisite research, chiefly by consolidating the HREC component of the process. We also believe that it has the potential to strengthen rather than weaken ethics oversight of multisite research.

Second, linking community consultation to the HREC process, by making the former a pre-condition of the latter, is problematic. Both are important, but they are qualitatively different steps. The *National statement on ethical conduct in human research* specifies that research methods be "respectful and acknowledge the cultural distinctiveness of discrete . . . communities or groups" and calls for "evidence of support for the research project from relevant Aboriginal and Torres Strait Islander communities."[29] On the ground, the engagement process involves trust and relationship building, and occurs at several levels. For example, basic courtesy dictates the need for introductions and reasonable notice before researchers "arrive". Logistical necessities, particularly when local staff are involved or the research intersects with existing services, demand another type of dialogue. Ensuring that community leaders are comfortable with and support the study requires a different form of engagement again — done well, it involves discussions before, during and after the field component of the research.

2 Entities involved in ethics review and consultation for the National Indigenous Eye Health Survey (NIEHS)*



* Shaded boxes with a solid outline indicate entities from which ethics approval was required; unshaded boxes with a solid outline indicate community organisations from which consent was not a precondition to approval by the relevant ethics committee; and boxes with a dashed outline indicate other state and national entities that were consulted, typically at the suggestion of an ethics committee or community organisation, whose consent was not a precondition to ethics approval.
† Although this was a hospital-based ethics committee, it operated as a committee with state-wide approval authority for purposes of the NIEHS. ◆

Drawing these various layers into the HREC process through a requirement of sign-off from community organisations runs the risk of making this part of the review haphazard, reductionist and artificial. In our experience, the basis for determining which community organisation's approval should operate as a precondition to HREC approval was unclear and variable. HREC expectations of the community's response — essentially a red or green light for the study — will often be out of step with the tenor of the dialogue between researchers and community members. Another way of articulating the problem is that HRECs tend to handle community approval as a kind of population-level analogue of the contemporary bioethics concept of a patient's informed consent, but the analogy is not well suited to the realities of community engagement.

We believe that a more appropriate model would be for researchers to include an outline of an engagement strategy in their ethics application. The strategy would detail the project's consultation activities, including the plan for approaching communities, how local Indigenous people will be engaged, and what governance arrangements will guide the process. The ethics committee would review the strategy and, through the standard mechanisms for ongoing monitoring of research projects, researchers would then report annually on the strategy's roll-out. Ethics committees should be notified promptly of any problems encountered or departures from what was approved, akin to notification of adverse events.

Third, any overseer of engagement processes must recognise the need for flexibility. In multisite studies, the processes will often need to vary according to the scope and nature of the research and the types of communities involved. In some discrete Aboriginal communities, the appropriate organisation to engage in the research process may be obvious. But when the Aboriginal community is a relatively small minority dispersed within a larger population group, the appropriate structure and process may be less clear; in such cases, researchers will need time to develop their strategy, and latitude regarding how it is executed on the ground.

Fourth, in parallel with the centralisation of formal ethics review for multisite studies, options for centralising community consulta-

3 Summary of the NIEHS ethics review and consultation experience

Overview

- Ethics approval was required from 39 entities (8 HRECs, 31 community organisations).
- Consultations were conducted with 34 additional community, state and federal entities.

HRECs

- Every jurisdiction except Queensland and Victoria required approval by a state-level HREC (or, in the case of Victoria, an HREC with state-level approval authority), and the Northern Territory required two separate state-level approvals.
- HREC type varied across jurisdictions: hospital committee (Victoria); state Aboriginal committees (New South Wales, South Australia, Western Australia); state government committees (Australian Capital Territory, Northern Territory, Tasmania).

Community organisations

- Consultations were undertaken with 41 community organisations (one or more in every jurisdiction; mean of 5.1 per state or territory).
- The most common types were Aboriginal medical services or boards (17) and community councils or corporations (15), which together accounted for 78% of community consultations.
- Community organisation consent was a mandatory component of ethics review in six of eight jurisdictions.
- For 31 of 41 consultations, community organisation approval was a precondition of formal ethics approval.
- Within jurisdictions, the numbers of consultations correlated strongly with the numbers of study sites ($r = 0.98$, $P < 0.001$).

Other entities

- Consultations were undertaken with 24 additional entities and organisations (21 state, three federal).
- These were suggested by an HREC or community organisation, but voluntarily undertaken (ie, ethics approval did not hinge on it).

Content of ethics reviews

- A total of 80 issues were raised: 60 by HRECs (mean number of issues per HREC, 7.5 [range, 1–26]) and 20 during community consultation and consent processes.
- Issues ranged from relatively minor concerns (eg, requests to supply details of insurance coverage) to substantial concerns requiring alteration of study protocol (eg, revisions to the participant information sheet and questionnaire).
- The most common issue types were:
  - requests to obtain approvals from additional third parties (10)
  - questions and concerns about benefits of study to participants and local community (8)
  - requests for amendments to participant information sheet (9)
  - concerns about arrangements with local study staff (7).
- Within issue types, there was a substantial degree of overlap in the specific matters raised — issues were rarely identical, but were often variations on a theme.

Procedural aspects of ethics reviews

- One HREC accepted prior approval from another committee; the rest did not.
- Seven HRECs accepted the standardised National Ethics Application Form (available at <https://www.neaf.gov.au/default.aspx>).
- Six HRECs required annual progress reports and two required 6-monthly progress reports.
- Six HRECs had different approval periods (ranging from 1 to 5 years) and the approval period was unspecified for two HRECs.*
- One HREC stipulated that manuscripts reporting findings from the NIEHS must be reviewed and approved by it before publication.

* Approval period refers to the period for which approval is granted. NIEHS = National Indigenous Eye Health Survey. HREC = Human Research Ethics Committee. ◆

tion processes should be explored. This suggestion will strike some readers as odd: how can local matters be handled by central bodies? Consider a committee constituted of local leaders and stakeholders from a mix of communities who convene regularly to review multisite study proposals, focusing on issues relevant to communities and special populations. The committee could be a standing one, but with several rotating seats to ensure a degree of representation from certain communities and groups directly connected with the project under review.

Critics may reject this last idea as destined to be insufficiently sensitive to local concerns. However, the goal must be a reasonable balance between the accommodation of local concerns and a level of efficiency that does not stymie valuable research. Tipped too far towards efficiency, the research may be ill-informed and lack adequate ethics oversight. Tipped too far towards local consultation, social benefits that flow from multisite studies in important fields of research, such as Indigenous health, will fall out of reach.

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Competing interests

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4 Issues raised during ethics review of the National Indigenous Eye Health Survey, by jurisdiction and type of issue*

	No. of issues raised by an ethics committee, no. of issues raised by a community organisation†							
	Victoria	New South Wales	South Australia	Western Australia	Australian Capital Territory	Northern Territory (Central)	Northern Territory (Top End)	Tasmania
Composition of steering committee or advisory group	—	1,0	1,0	1,0	—	—	—	—
Details of investigators	—	—	1,0	—	—	—	1,1	—
Arrangements with local study staff (eg, recruitment, training, remuneration)	—	—	0,2	0,2	—	—	3,0	—
Additional third party consent (eg, community groups, government agencies)	—	1,0	1,0	1,2	—	1,0	2,1	1,0
Additional third party consultation (eg, local clinicians)	—	1,0	1,0	1,0	—	1,0	1,0	—
Cultural safety (interpreters, language issues)	—	—	—	—	—	2,0	1,0	—
Data access (medical record review)	—	—	—	—	—	—	1,0	—
Site selection method	—	2,0	—	0,1	—	—	1,0	—
Recruitment strategy	—	2,0	0,1	0,1	—	—	—	1,0
Logistical arrangements (eg, accommodation, transport)	—	—	0,1	0,1	—	—	0,1	—
Benefits to participants and local community (eg, sharing of findings, community enrichment)	1,0	1,0	1,0	0,2	—	—	1,2	—
Follow-up	1,0	1,0	1,0	0,1	—	—	1,1	—
Data ownership, retention and security	—	1,0	—	—	—	—	2,0	—
Indemnity coverage	—	—	—	—	—	—	1,0	—
Participant information sheet	1,0	—	—	—	1,0	—	6,0	1,0
Consent form	1,0	—	—	—	—	1,0	2,0	1,0
Questionnaire (wording, structure)	—	—	—	—	—	1,0	1,0	—
Administrative aspects of application (eg, response option choices, spelling, grammar)	—	—	—	—	—	—	2,0	—

* Data for seven states and territories only are shown as the study did not undergo ethics review, and no issues were raised, in Queensland. † Issues raised by a community organisation from which approval was a precondition to approval by the relevant ethics committee. — = No issues raised. ◆

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