

The Process of Informed Consent What's at Stake?

Final Report

Arlene M. Katz, Ed.D.*
Dept. of Social Medicine
Harvard Medical School
Boston, MA

and

Kenneth Fox, M.D.
Erie Family Health Center
Chicago, IL

August 23, 2004

* corresponding author: arlene_katz@hms.harvard.edu

This report was composed in Adobe FrameMaker™ 6
and typeset with Adobe Acrobat Distiller™ 6.0.

© Copyright Children's Hospital Boston 2004
All rights reserved.

TABLE OF CONTENTS

Preface	v	Discussion	21
Introduction	1	‘Understanding’ in the informed consent process ..	22
The Process of Informed Consent:		What is in the word ‘understanding’?	22
What’s At Stake?	1	From recall to remembering	23
Background and Significance	3	Pivotal Moments	24
Literature Review	3	Recommendations	25
Research Design and Methods	5	Informed Consent is Relational	25
Data analysis	6	Navigating different ‘worlds’, interests and	
Table of Cases	7	meanings of families, researchers and IRB	25
Results	9	Collaboration	25
Sources of Data	9	Enhancing opportunities for creative	
Thematic Summary I (Researchers)	9	intersection between ‘worlds’ of	
Theme 1R: Informed consent as ‘relationship’ ..	9	research and clinical investigations	26
Theme 2R: Communication	10	Continuing the dialogue	26
Theme 3R: Motivations in the informed		Issues in existing relations	27
consent process	11	Issues and Concerns	28
Theme 4R Culture of research institutions	13	Time	28
Thematic Summary II (Subjects)	14	Uncertainty	29
Theme 1S: Motivations for participation	14	From isolation to community	29
Theme 2S: Experiences of the informed		Final recommendations	29
consent process	15	For researchers	29
Theme 3S: Structure of the informed		Families recommendations for families	30
consent process	17	A concluding comment	30
Theme 4S: Politics of research	18	Acknowledgements	31
Thematic Summary III (Policy Makers)	19	References	33
Theme 1 PM: What is informed consent ?	19	Author Index	35
Theme 2 PM: Administrative challenges	19	Subject Index	37
Theme 3 PM: Politics	19		

PREFACE

*It would be helpful to get data that would actually give us an insight on how this experience of informed consent is for the patient. Because there's one thing that I often question as I am doing it, you know, how does this feel for the patients. (V p.1)*¹

Informed consent as a procedure has developed largely along administrative lines. It has focused on particular issues (regulatory, legalistic, bureaucratic), while paying little attention to the experience of subjects, or how researchers actually go about the process of obtaining informed consent. From a regulatory perspective, we know about the importance of risk/benefit ratios, of transparency and disclosure; of the importance of understanding as recall, *e.g.*, of the purpose of the research. In the current study we take this a step further and look at how the process of informed consent functions *in practice*, to learn what actually goes on in every day meetings among stakeholders. In situating ourselves within the practice of informed consent, we have had the benefit of exploring a range of issues not explicitly addressed in standard doctrine and procedure, seeing them instead from the multiple perspectives of the actors involved. We report on facts and concerns that are as real and present as the regulatory issues themselves: how people remember their experiences with informed consent; what is at stake for them, not only in terms of their participation in research, but in how it affects their lives. This has far-reaching implications, not only regarding the public perception of research as understood by the Office for Human Research Protection (OHRP), but also in the domain of informed consent as a moral enterprise.

Before describing our study, we should like to acknowledge the integrity of the people who participated in this research project: the extent of interest and involvement shown by the clinical investigators, research nurses, and coordinators and by the young patient/subjects and their families at Children's Hospital. Rather than being seen as an instrument of surveillance or evaluation, we were invited in to the medical 'cultures' of research to learn about the process of informed consent from and with each stakeholder. While understanding that these are sensitive issues, and that informed consent can become problematic, we invariably found a high level of respect and empathy for the others' position. Researchers were prepared to send subjects to the PI (AK), and specifically directed her to people who felt that informed consent was problematic, or who declined to participate in a particular study. Principal investigators (PIs) in four departments went out of their way to introduce her to other PIs and to their research staff. In this spirit of collaborative inquiry, researchers and PIs often gave permission for her to observe their consents and also to be interviewed on more than one occasion. Through their commitment to learning from the families, and through reflecting on the practice and challenges of informed consent, we became an informal 'community'. AK would also like to thank the IRB administration for inviting her to observe their meetings, and the IRB members and researchers who took part in the initial phases of the ethnography by meeting to reflect on what they saw as the most important issues, concerns, opportunities, and conundra in informed consent—both as a practice and as policy. We hope the specifics of this report, the issues, problems, and recommendations of each culture: families, researchers and policy makers, will contribute to enhancing the practice of informed consent.

¹ Within this report, references to interviews of research subjects or their parents are indicated by a single letter (A–Q), members of the IRB by a doubled letter (AA–HH), and researchers by a roman numeral (I–XVI). These symbols are followed by the page number of the quotation in the transcript. (See the table on page 7.)

INTRODUCTION

The Process of Informed Consent: What's At Stake?

This report, based on original fieldwork conducted over 15 months, is organized into the following sections:

- Literature Review/ Background and Rationale
- Study Methods
- Results
- Discussion
- Recommendations

Federal regulations regarding the protection of human research subjects state the basic requirements for documenting that a properly informed consent has been obtained. However, these regulations describe the process only in vague, general terms open to multiple interpretations. This ethnographic study represents a systematic inquiry into the *relational aspects* of informed consent.

The purpose of the study was to explore and describe the most important relational aspects of informed consent from the points of view of stakeholders directly involved in it. We used ethnographic methods to address the following questions: What goes on in the process of informed consent? And what is at stake for participants?

From the start we were interested in using anthropological methods to achieve a unique outcome: We aimed to “tune in” to and amplify the voices of research subjects and researchers, as well as policy makers in the setting as they reflected on the everyday practices in which they engage.

Moreover, we engaged in a process of participant observation as we developed our research protocol and shepherded it through two separate IRBs at two preeminent research institutions: Boston Children's Hospital and Harvard Medical School. During this time, IRB members were interviewed about their experiences of informed consent.

The study was located at The Children's Hospital main campus among a network of researchers from several departments who regularly submit their proposals to IRB committees in order to conduct their work. Subsequently, researchers identified research subjects for our ethnographic study who became key informants.

Research subjects had been recruited in the past to participate in research studies across a wide range of conditions, risks and benefits. Some had granted their informed consent while others declined. In both cases, subjects agreed to participate in the present ethnographic study.

The discipline of listening critically to the concerns of the different stakeholders—and especially research subjects themselves—may lead to innovations in practice that strengthen relationships central to the *social process* of informed consent.

Since its original formation in 1972, the IRB of the Boston Children's Hospital has recognized that obtaining the informed consents of parents and (where appropriate) the informed assent of minors goes beyond the signing of a consent document. Assuming that informed consent as a *process* should begin at the time of recruitment and continue throughout the course of the study, the IRB has explored several avenues for improving the informed consent process.

The original NIH grant, out of which the current study is funded, proposed to conduct a systematic investigation of the informed consent process as it is currently practiced at Children's Hospital, as a basis for exploring more precisely what the process is, and how the current consent process could be strengthened.

The Federal Regulations regarding protection of human research subjects clearly stipulate the basic requirements for documenting that a properly informed consent has been obtained (46 CFR, 46.117). The regulations also acknowledge that a properly written and signed consent document by itself is not sufficient to guarantee that research subjects have been properly informed about the risks and benefits of their participation in clinical studies. Sections 46 CFR (46.101, 46.109, 46.111, 46.116) and Subpart D of the Federal Regulations have described some of the conditions under which informed consent is to be obtained. The regulations address the basic elements of informed consent but they describe the process only in general terms that are open to multiple interpretations and misinterpretations.

Literature Review

A clear consensus has emerged that the informed consent process is far more important in principle than the methods used merely to obtain a signed consent document. However, a review of the literature suggests that little is known about patient/subjects and families' experience of the process.

"There are few data on the experiences of real parents who have been approached for consent" reports (Stenson, *et al.*, 2004, p.F321) and he adds, "There is a clear need for further work involving patient groups looking at ways in which the process of participation in clinical trials can be improved" (p.F323).

The relatively recent inclusion of children in clinical research has increased the need to understand how the family of a child who is a potential participant in a research study understands and experiences the informed consent process.

Children as research participants constitute a very vulnerable group largely because of their cognitive and emotional development, lack of control and autonomy in the medical context and their dependence on clinicians and parents and susceptibility to their influence (Knafl, 2001; Broome *et al.*, 2001). While some studies have looked at the consent process for child participation, there are no studies that examine this process from the perspective of the families as they proceed through the process. The present study uses an ethnographic and qualitative approach to the informed consent process specifically focusing on the voices of the participant families.

The literature also suggests that there is considerable need for more research on the process of informed consent involving children and parents (Sugarman, 2003; Mason and Allmark, 2000; Kodish, 2003; Nelson *et al.*, 2003; Olechnowicz *et al.*, 2002). Studies suggest that the informed consent process frequently may not be meeting its desired objectives, and may be leaving children and families with an inadequate understanding of the research as well as discomfort and dissatisfaction with the circumstances of the decision-making process (Sugarman, 2003; Kodish, 2003; Nelson *et al.*, 2003; Stevens and Pletsch, 2001).

It is not clear what accounts for parents' inadequate understanding of research protocols. A study seeking to assess parents' understanding by short-term recall of the consent experience points to a failure to recall the information as evidence of poor understanding of the informed consent process (Nelson *et al.*, 2003). However, this "failure to recall" is subject to a variety of interpretations and does not itself explain the reasons for poor understanding. It would therefore be important to understand parents' and families' approaches to making decisions about whether to allow their child to participate in a research study and how they perceive this process. This could serve as an important basis for addressing those aspects of the process that families experience as obstacles to their understanding and their ability to make such critical decisions. Ideally, this would also result in reduced feelings of regret and self-recrimination (Stevens and Pletsch, 2001). It is not our purpose to look at 'failure' or assign blame. Rather, it has been our aim in the current study to seek 'equipoise' between researcher and subjects, to place 'understanding' in a context that makes visible the two-way nature of understanding, and to clarify the opportunities for 'dialogue' between researcher and patient/subjects and their families.

There is a need to better understand the nature of assent and parental permission (Kodish, 2003; Nelson *et al.*, 2003; Olechnowicz *et al.*, 2002; Young *et al.*, 2003), particularly regarding the nature of the understanding, and in instances where it is inadequate, what specifically about the informed consent process might impede it or invite opportunities to learn with participants about what does work. Our study focused on articulating the experience of the process of informed consent and on identifying those elements that are most valued by parents and children—we design a process in which all involved can feel included as equal participants (See “Research Design and Methods” on page 5.)

For example, where informed consent conferences (ICC) are held, the presence of the child appears to affect parental behavior and possibly the outcome (Olechnowicz *et al.*, 2002). Young people have also reported feeling marginalized in consultations about their care (Young *et al.*, 2003). Children appear to have varying degrees of capacity to consent, assent, and dissent at various ages (Nelson *et al.*, 2003).

There is evidence that whether the illness is acute rather than chronic creates circumstances that substantially affect parents' ability to make the distinction between therapeutic benefit and research (Pletsch *et al.*, 2001). When the illness is acute, parents experience greater confusion, tending to believe that there will be some direct benefit (Pletsch *et al.*, 2001). A focus on the consent document may sometimes be at the expense of the informed consent process (Kodish, 2003). This emphasis may be contributing to the confusion that parents often have in understanding the difference between treatment and research (Kodish, 2003). By focusing on the experience of families as they make decisions regarding participation, our study was able to learn from and with them what is at stake, as well as to identify those aspects of the consent process that may be inhibiting a clear understanding of this distinction.

The immediacy of the threat to life in acute cases (versus chronic, *e.g.* diabetes) tends to create a greater sense of urgency and the need to “rescue the child”, and consequently may inhibit a parent's ability to fully understand the proposed study (Pletsch *et al.*, 2001). The “fast trajectory” following diagnosis of an acute condition, *e.g.* cancer, can cause parents to feel severe emotional stress that may further restrict their ability to make a rational decision and to fully

understand critical information during the consent process (Pletsch *et al.*, 2001). Additionally, the immediacy of the threat to life in acute cases may also compromise voluntariness in some cases because of the emotional vulnerability of families while dealing with the acute condition of a child (Nelson and Merz, 2002). In our study, we felt it important to address how this is experienced by families and in what ways the process may be modified to enhance feelings of voluntariness even in circumstances of considerable stress.

Studies also suggest that the timing of the consent process can greatly affect families' experience of the process. Time pressures to make a decision within 24–48 hours following diagnosis can be overwhelming for families (Stevens and Pletsch, 2001). For example, parents learning of a leukemia diagnosis and having to decide whether to allow their child to participate in a bone marrow transplant study experienced overwhelming stress and later felt regret and self-doubt about their decision (Stevens and Pletsch, 2001). One study suggests that if mothers are not given sufficient opportunity to acquire understanding and confidence in their decisions, long-term self doubt and blame may result (Stevens and Pletsch, 2001). Furthermore, there is some evidence that feeling pressured and not really understanding the study protocol may result in more refusals to participate (Sugarman, 2003). Clinicians, investigators, participants and their families would all be well served by the development of strategies that enhance the experience of informed consent for participant families and minimize ill-feelings regarding the process.

The literature also has shown that cultural, ethnic, and racial diversity of potential participant families may affect their experience of the informed consent process (Nelson and Merz, 2002; Fisher, 1999; Allmark and Mason, 2003). Socio-economic status, disease status and family position are also risk factors for greater vulnerability to undue influence or coercion in the informed consent process (Nelson and Merz, 2002). Potential power asymmetries, real and perceived, need to be identified and minimized in order to ensure meaningful and voluntary participation in the process (Fisher, 1997; Titus and Keane, 1996). This study placed our findings in the context of cultural diversity and informed consent as a social process.

The investigators (Drs. Katz and Fox) chose qualitative methods of ethnographic inquiry as most suited to address the central scientific question posed in the current study: What ‘goes on’ in the informed consent process; what is at stake for multiple participants? what is the experience of informed consent over time? To address how events or a process changes over time, we draw on a case-centered approach as most effective to focus on the particularities of often complex circumstances in an effort to delineate key aspects (Mishler, 1996; Katz and Mishler, 2003). This study provides a rich qualitative background and narratives offering the voices of the participants and their families in different settings (different cases) articulating how they experience the informed consent process, how both children and parents come to understand those experiences; how they talk about them and what everyday practices comprise them. This qualitative ethnographic approach and the multiple methods it entails, allowed for exploration of the experiences of multiple stakeholders, and how they come to understand the informed consent process. It can inform efforts to improve the process by accessing the experience of the participants and their families, and how they come to make meaning of it in the complexity of their everyday lives (Kleinman, 1995).

This qualitative study used ethnographic fieldwork methods that are standard in anthropology which include: 1. interviews, field notes, and participant observation at group trainings and other sites that emerge in the course of our research, where we can learn about informed consent in the culture that is unique to Children’s Hospital in the larger context of clinical research; attendance at national meetings and public events relevant to informed consent; 2. observations during interviews between physician and family and research staff; 3. interviews with individuals, parents and children and researchers using a semi-structured open-ended format.

The investigators developed the issues around which semi-structured interviews were organized, drawing on literature reviewed as well as the formative conversations with IRB members, clinicians and research coordinators. These issues focus on informed consent as a longitudinal process, not just the signing of a consent document, but experiences before, during and after the signing. In semi-structured interviews, the interviewer has greater latitude in the sequencing of questions, their exact wording, and the amount of time and attention given to different topics (Robson, 1993; Fon-

tana and Frey, 2000). Thus, in being responsive to leads provided by the interviewee, questions can not be dictated solely by the interviewer. Questions that are meaningful to the participants cannot be determined in advance but are allowed to develop in conversations with subjects. The person interviewed indicates the direction they are willing to go; it is their experience rather than our questions that we follow. Thus, our style of interviewing privileges listening to the views of child/subjects and their parents, and what we can learn from their experience. Ethnographic interviews provided us with nuanced discussions of the feelings and reasoning behind participants’ experience of informed consent and how they went about making decisions to participate in research; such content is more likely to surface in the context of a face-to-face conversation. The numbers of subjects included a range of possible cases, participants and themes; to reflect the diversity of the Children’s Hospital setting we used the method of purposive sampling, that involves selection of key informants best positioned to answer the research question (Barbour, 2001).

The project was conducted in two phases that formed part of the ethnography:

Phase 1. In the *exploratory phase*, the PI (AK) attended IRB meetings, professional trainings, and national meetings and conducted interviews and had ad hoc conversations with a subset of IRB members and staff, clinicians and research coordinators to determine a focus most pertinent to the context of Children’s Hospital in part by identifying what researchers, IRB members and policy makers see as the most important issues that they have encountered in the informed consent process. Through meetings with these various ‘stakeholders’ we developed an orientation that focused on process and participation rather than prescription and surveillance. Thus our study has not been regulatory but rather a process of co-learning and mutual inquiry (Katz *et al.*, 2000; Fisher, 1999). We sought to discover the central issues of the informed consent process from multiple viewpoints and how these can shed light on refining and enhancing the process: parents and child/subjects; clinical investigators, research staff, IRB members, CCI staff, and other clinicians.

Phase 2. *Case finding:* In order to capture the various cultures of Children’s Hospital, we situated our study not only in the main campus of the hospital but also opened enrollment to the virtual network of researchers who submit their work to the IRB. Thus, our field site is the community of

Children's Hospital: the hospital campus, the research buildings, and the affiliated community sites where research happens connected to the IRB. Our subjects were drawn from eight studies, in four departments, across the range of risks and benefits. Sites included specialty clinics, inpatient, outpatient and intensive care units.

All clinical investigators conducting research and their research staff received recruitment information by e-mail or telephone asking them to identify potential subjects and their parents to be interviewed about their experience of informed consent in context of current or previous studies. A letter was provided for parents; the PI (AK) was available to provide information and answer any questions. Clinical investigators and research staff initially approached subjects; if there was interest shown in participating, we contacted parents to further discuss the study and to schedule a meeting with child/subjects for the purpose of informed consent and assent. patients/subjects and their parents were asked to participate in an one hour long interview, at a convenient time (*e.g.*, that coincided with other hospital or clinic visits. Where it was not convenient geographically, parents and children were offered the option for a telephone interview. The PI observed informed consent interviews between physicians or their designated research coordinators and families, where appropriate.

All participants (parents, children and researchers) gave permission to have interview sessions audio-taped. Nine families (parents and children together and separately) were interviewed face to face; Two families (parents and children separately) were interviewed by phone; an additional three families (parents and children separately) were interviewed by phone, following the face to face interview for a total of twelve families. Seventeen researchers were interviewed: 6 PIs and 11 research staff. Some families and researchers were interviewed more than once, for a total of 41 interviews. Three researchers were observed conducting informed consent interviews (see the table on page 7 for a summary.) In addition to doing interviews, observations and field notes provided additional background information and

features of the context in which the interview is being done, as well as other aspects of the hospital culture.

Initial meetings with IRB members and researchers generated issues and concerns about informed consent that we hoped to illuminate in our study. These issues were modified in an iterative fashion through interviews with parents, families and researchers. Initial concerns and themes included: 1) What do families recall about the circumstances in which they were asked to participate as a research subject?; 2) Motivation: what went into parents and children's decision to participate in research?; 3) Being approached for consent/assent, by whom and how were they asked?; 4) What does participating in research means to parents and children?; 5) Saying 'yes' and saying 'no' to research, including differences between parents and children; 6) What advice would they give to other families, researchers about the process of informed consent?

Data analysis

The data being gathered was qualitative: interviews, informal conversations, field notes and personal narratives. Interviews were audio-taped and immediately coded to preserve anonymity. The interviews were audio-taped and transcribed by a member of the research team (AZ). While we will be focusing mostly on interviews in this report, we will be relying on the PI's (AK) observations and field notes as well.

Our interdisciplinary research team (AK and KF), with backgrounds in psychology, anthropology, medicine) each reviewed the transcripts to identify significant themes, compare responses and draw conclusions, using triangulation to compare and analyze differences among the responses and multiple views on an issue (Giacomini and Cook, 2000; Mays and Pope, 2000; Malterud, 2001). We identified themes, meaning domains and cases from the data to illuminate focal issues about the process of informed consent (Mishler, 1990; Katz and Mishler, 2003). Analysis focused on themes, without regard to particular individuals: the report contains selected quotes and composite examples to ensure confidentiality.

TABLE OF CASES

Study	Risk/benefit	P.I.		Research Staff			Subjects			
		ID	Inter-viewed	ID	Inter-viewed	Observed	ID	Consented to Clinical Study	Interviewed	Age of Child
1				XV		✓				7 days
	> minimal, poss. Benefit						A	✓	Mother	8 weeks
2	> minimal, poss. Benefit			II		✓		×		5 days
3	> minimal, poss. Benefit				✓		C	×	Mother	11
	> minimal, poss. Benefit	I	✓	XVI			B	✓	Mother & Father	18 mos
	> minimal, poss. Benefit				✓		D	✓	Mother	2
4	minimal, poss. Benefit		✓	II	✓	✓	E,F	✓	Mother, Child	19
	minimal, poss. Benefit	XIII		III	✓		O	✓	Child	14
5	minimal, poss. Benefit	IV	✓	VI	✓		I	✓	Mother & Father & Child	14
	minimal, poss. Benefit			V	✓		G,H	✓	Mother, Child	14
6	> minimal, poss. Benefit			X	✓		L,M, Q	✓	Mother & Child, Mother, Child	17
7	> minimal, poss. Benefit	VIII	✓	IX	✓		N	✓	Mother & Children	5 (twins)
	> minimal, poss. Benefit						P	×	Mother	5½
8	> minimal, poss. Benefit	VIIa	✓	VIIb	✓		K,J	✓, ×	Mother, Child	14
9		XIV	✓	XII	✓					
			✓	XI	✓					

Sources of Data

The ethnographic study was conducted by the PI (AK) over 15 months in outpatient clinics, inpatient wards, waiting rooms, laboratories, and research offices at Children's Hospital in Boston, MA. Once informed consent had been obtained, a total of 41 formal, semi-structured, open-ended, face-to-face interviews were conducted, recorded, and transcribed. There were 17 interviews with researchers/research staff members (physicians, nurses, study recruiters), 17 with research subjects, and 7 with IRB committee members. Some respondents were interviewed more than once or in group settings. In addition, three researchers were observed conducting informed consent interviews. In sum, the formal interviews yielded over 600 pages of transcripts, which were subsequently checked for accuracy by the research team.

Fieldwork also included attendance at twice-monthly IRB meetings, monthly Ethics Consortium meetings, and researcher training sessions. The ethnographer (AK) also participated in three national professional meetings (IOM, ASBH and PRIMR), directly observed instances of study recruitment and informed consent in "real-world, real-time" practice in the field setting. She also conducted informal, open-ended, ethnographic interviews among respondents and with leading scholars in the field of informed consent and medical ethics. Over 100 pages of field notes from these encounters were recorded. While we shall be focusing mainly on interviews, we'll also be relying on these observations and field notes. The table on page 7 summarizes the formal interviews, *i.e.*, the numbers of researcher and subject respondents, their departmental/study affiliations, and triangulation of interview materials with other forms of ethnographic data.

In addition, fieldwork included the collection of an extensive library of documentary resources. These include books and scholarly papers about informed consent and medical ethics; IRB protocols and amendments to those studies in which the researchers and subjects of the current ethnography are engaged; local newspaper clippings on informed consent; subject/patient education materials created by clinical researchers, IRB and Ethics Committees; e-mail communications between IRB committees at Children's Hospital, Harvard Medical School and the ethnographic researcher team; and finally, hard copies of relevant web pages cited by respondents (*e.g.*, <http://www.guineapig.com/>).

Thematic Summary I (Researchers)

The transcripts of interviews with clinical researcher/investigators were indexed according to a set of four core themes that were identified by the research team through an iterative process of transcript review, discussion, and inductive analysis during weekly conferences over a 6 month period. These themes are summarized here: (1R) "Informed Consent as a Relationship"; (2R) "Communication"; (3R) "Motivations in the informed consent process"; and (4R) "Culture of Research Institutions."

Theme 1R: Informed consent as 'relationship'

In sharp contrast to the "official" discourse on informed consent characterized as regulatory, legalistic, bureaucratic, technical and textual, clinical investigators interviewed for this study told us that they experience informed consent as being fundamentally about interpersonal relationships. Emblematic of this finding are the following quotes from two prominent clinical investigators:

It shouldn't be just a written word, but there is a relationship that develops between you and the individual with whom you are speaking during the consent process... (I p.1)

It's about a relationship. And for me signing that piece of paper is the first step in that process. It's what's required by law. But I really don't see that as anything but a first step." (VIa p.5)

Many researchers described the development of the informed consent relationship as a process. For example:

Basically the thing I've learned is that it is definitely a process. It is not a one time deal. And I am lucky that I'm at a place where I can take a couple of days to make sure the family understands what they signed up for... Like I said, it's a process. Can you pinpoint an exact time the informed consent happened? (V p.4)

They frequently elaborated on the descriptive features of the process in which the informed consent relationship develops. Many emphasized the importance of the following qualities in these relationships: "trust", "honesty," "caring," "empathy," "sensitivity," and "awareness of the subjects' vulnerability":

The way I see it is that I assume with every family that part of what they are doing is making themselves vulnerable—whether they tell me or not, whether they

realize it or not. And my job is to be vigilant, to be really sensitive, to be really open and have my antenna up. To say, “Hmm. What is the sub-text of what you just said.” (VIa p.7–8).

A lot of them have concerns about participating in research. I feel that this is a vulnerable population. Many participate in studies but don't really understand what goes on. I feel that if you're not very open and honest with them, then they cannot really understand what participation really means.... So that is something I really try to do—make sure they understand the commitment. (XI p.2).

Many saw the relationships as opportunities to give advice, to advocate for the subject/patient, and to empower the subject. Moreover, the researchers often pointed out that the process of informed consent unfolds in a complex social context shaped by family dynamics, racial identities, economics, and power/authority:

I don't believe knowing stuff is benign. I think there are so many issues about identity and relationship. What does it mean within a family? All of those dynamics are something I am very committed to working on with families.... [Research we're asking them to consent to] has economic connotations and legal connotations. I mean we haven't seen that much discrimination. Is that because we live in a benign society? I don't think so. (VIa)

Most clinical investigators also described an extraordinary aspect of informed consent relationships—their transformative power—*i.e.*, the “pivotal moments” which can occur during the process of informed consent, and which change all of the stakeholders—researchers, subjects and staff alike.

That [consent] was such an eye opening experience for me. The issue of the parent wanting one thing and the child wanting another was a really big turning point for me. This became a situation that was so empowering for the child that I truly believe it helped him mount an offense against his infection. It was like wow, this is really powerful. (VIIb p.9)

Theme 2R: Communication

Clinical investigators spoke forcefully about the importance of communication in the informed consent process. They described the qualities of communication they value most and detailed pitfalls to communication in great depth.

Many discussed the importance of being “up front and honest,” although a recognition of communicative tensions between stakeholder interests also seemed critical:

Actually, you know, it's important that they hear the information and decide for themselves whether they want to participate, but I do have a slight feeling that this is just one more assault on the patient... So I try to be sensitive as possible and still have the agenda that [I] have. (VIIb p.1)

Clinical investigators aimed for a communicative approach to informed consent that allows for “interaction” (II p.4), is “conversational” (II p.3, V p.8, VIa p.5,10, VIb p.1, VIII p.8), and “open to feedback” (II p.3), “clear” (XI p.1, VII p.11, IXb p.1), “shows no arrogance or egotism” (V p.9–10), “contains little jargon” (VIII, p.2), is “does not pressure” or “coerce.” (III p.8, V p.4, VIa p.5 and VIIb p.11; XII) and is “voluntary.” (II p.1, III p.1,7, I p.2,4, IX p.1)

Make sure they know it's completely voluntary. I always stress that at the end. (III p.7–8)

In the ideal case the process of informed consent will “urge deliberation and consideration” (VII p.8) and never seem “exploitative” to subjects. Many investigators also rejected communicative approaches characterized as “selling,” “spinning,” “soliciting” or “begging” subjects to participate in research.

What am I doing? Am I being a salesman? Am I being a clinician?... It's the whole idea of making sure we are being non-coercive, just making sure they are doing this because they want to, not because they want to please you or their doctor... Have you heard of active listening?... I think it means providing the [subject] with a comfortable space to speak about issues involving them. Being able to provide some feedback so they can take the conversation or thought a little further and be able to recognize my limitations.... It's a very complicated fine balance, providing some psycho-social support [to urge deliberation] but making sure you don't take them to that place where they won't be able to cope.” (V p.4–5)

This, of course, is connected with the researcher's sensitivity to the need to establish an appropriate “relationship” with their patients/subjects (see Theme 1R on page 9.) Another researcher remarks on the importance of “conversation”:

AK: And, what do you think are the most important issues in the informed consent, having both worked clinically and in research?

Researcher: I think the most important is, the way that you present the study. Giving the most information to families, answering all their questions and having it be a conversation instead of being a one-way presentation. I think the most successful informed consents I've done

when there have been interaction, the families have grasped something and asked for feedback or asked questions. When they ask questions, I really know that they are comprehending. And that's one of the key things is getting some feedback. Sometimes I'll give the family the information and there will be silence. And I'll ask if there are any questions and they'll say no, and more and still no questions. So that makes me kind of a bit worried that they might not be hearing everything because of the anxiety level or fatigue or something like that. So the key thing I think is having a discussion with them and eliciting some feedback, whether it be questions or comments or anything (II p.4).

The aims of communication from the investigators' perspective were also well described. While some held that the aim of clinical research is "to enroll people" and "to convince them to participate," they were unanimous with regard to the aim of increasing subjects "understanding." This is a most important theme, and we have devoted a special portion of the "Discussion" section on page 21 to it. They felt that the aims of communication also include: that subjects should "know their commitment" and "grasp the expectations," "are clear on risks and benefits," should be aware of "what can be lost or gained" during participation; and should "know why they are doing this."

In order to achieve the communicative aims of informed consent, the investigators discussed the mechanics of presentation. Many noted the power of the language of consent as well as the style in which it is delivered. Both "phrasing" (XI p.1) and "pitch" of voice matter (VIIb p.7, VIII p.5). To quote another:

I think personally that the most important thing you can bring forward is that people get so hung up on the language of the informed consent, which is really important, but they don't spend enough time on the delivery of the consent. The study isn't ethical just because the form has gone through the informed consent committee [or] because somebody signs it. The delivery of informed consent is how we can be sure people understand as much as they can... Interpersonal and non-verbal dynamics of informed consent don't get quite enough attention. (I p.9)

Many also noted the importance of non-verbal communication (I p.9, II p.1, IV p.3, V p.2, VI p.9):

It's more than words. Basically it's more about body language, I think. The way parents are looking at each other, the way they are looking at the child, or you just get a general gestalt of what is going on in the room

sometimes. I guess being in such situations plenty of times, there are things you kind of [learn] to pick up on. (V p.1)

I think I've learned to be more perceptive [during the informed consent process], and more appreciative of the nonverbal cues and how to communicate a little better. (II p.6)

In contrast to the "official" and regulatory discourse on informed consent which urges standardization of the process, most investigators commented on the need to personalize their communications with potential informed consent subjects in order to help them understand better what is being asked of them. They felt the need to use their judgement to know when it was best to explore a possibility (and when not to do so):

I don't have any rules in my head. It's just that I meet people and I start talking one way and depending on the questions and things they say, I'll answer their questions in a different way... I mean everything is in the consent. You pretty much have to explain, but the way I talk about that—I tailor. (III p.2)

I try not to just view them as just a person who's going to be part of a huge group participating in the same study. I've viewed them as individuals, people with different understanding and different needs, different interests, different questions. (XI p.9)

So it's definitely not about a piece of paper, though the legal department probably disagrees. But it's really about people looking at what they really want to know and what they don't want to know. (VIb p.1)

Theme 3R: Motivations in the informed consent process

Researchers reflected on motivations that drive the informed consent process (which is also elaborated by families). We comment on three major motivations that were expressed in our interviews below.

First, "altruism" is an important word with complex meanings for the informed consent process among all researchers interviewed.

There's altruism and gratefulness. It is interesting that some parents have it and some don't. Some parents will say, "My son or my daughter would not be here and having such success if there weren't babies [who were part of studies] before him. And others are just not interested in the process. It's very variable. (I p.7)

A fairly common thing people say is, "if there's something I can do to help make things better for future children." I often hear that from families when they are

about to consent to the study because they'll appreciate the big picture of why we are doing this study and that we are trying to improve things for the future. So they'll say, "You know, if I can contribute to the future it's best for my baby because people who contributed in the past made this possible for my child." (II p.4)

And I am trying to get back to explaining more about it and she said: "If it helps people, I want to consent. And she didn't care about the rest of the [form], she just wanted to know that it was helping someone." So there is her reaction and there are a lot of people who react in that way. (III p.2–3)

Interviewer: Do people ever say what went into their decision to participate?

Researcher: A lot of times it's basically, hopefully we can help out our son or daughter, and if not, then somebody else in this situation of his future kids. So it's very much the altruism of this society at some level. Altruism is a wrong word, but it's close. (V p.10)

If it's really for scientific knowledge... I am not sure if you'd call it altruism in the sense that you would do it for somebody who didn't have a disease. Let's say you would serve as the normal control for some neurological test because your next-door neighbor has MS and they are looking for age matched normal controls. Even if it's your next-door neighbor I would call it altruism because you don't get anything out of it. If you sign up for a treatment study, when I just told you I would give you exactly the same treatment off study because I really think you need it anyway, I would say that would be a perfectly good reason to be an 'altruistic' participant. "You already told me, Doc, that you are going to give me the same treatment anyway. Why should I give my name to the government and let you poke me 12 extra times unless I think it will help the field?" I think some families expressed that [form of altruism].

The investigator continues:

If you knew the trials were going to be positive, it's sort of in [your] self-interest [to participate]. But the trials may be no good. And if that is the case, if there is no change, then the study will [stop] recruiting and be should shut down. That's because it [participation in research] isn't just 'altruism,' it's really more like enlightened self-interest. (VIII p.6–7).

Second, researchers discussed the rôle of assessments of risks and benefits in decision-making about study participation. Many distinguished between the bureaucratic, adminis-

trative, theoretical and legal aspects of risk assessment on one hand and the "real" risks to subjects on the other:

The trickiest part is to figure out what the real risks of the protocol are as opposed to the paperwork risks. Just for example, the parts that need to be expressed—say three pages of HIPAA stuff—but are not what I want to get across the most.... Like what are the side effects of the medicine and how common are they. The real risks are the ones that happen more than 1 in 10,000 or bad side effects with the first dose. (VIII p.1)

Management of risks is accomplished during the informed consent process in different ways. First, the informed consent form attempts to cover the administrative or "paperwork" risks adequately:

Some people stumble on what I call a lawyers' paragraph. There's a paragraph in every consent form that comes through here that says, "in the event of an adverse event related to the research study, that the hospital reserves the right to bill your insurance company" etc., etc. That one always takes a fair amount of explaining. (I p.4)

Second, "real" risks are dealt with through a relational, communicative process fully alive to subject's predicament and the stakes at hand.:

I'd rather just chat to them about [how to make the decision to participate or not]. The paperwork is an impediment. It gets back to where we started. Paperwork sometimes becomes an impediment to understanding. (VIII p.8)

Researchers pointed out that the calculus of risks and benefits varies across different kinds of studies and situations. The stakes change according to the type of study as well as the acuity and severity of the subjects' problem or affliction:

In order to get into the study you have to have an infection that extremely serious and could be fatal. The medication [being studied] is very potent and very expensive, so from that perspective it is a big deal. The drug was not developed for this particular infection, but knowing how it works [suggests] that it would work in this circumstance. The risk of taking the drug is far outweighed by the [potential] benefit. The study itself is not risky insofar as we are just trying to collect information on patients that would be getting the medicine anyhow. It's not risky to be in the study, it's risky to have gotten into the circumstance where you would have to be taking the drug. (VIIa p.3)

They are different. A study that is just observational and takes one day, you know, that is just sort of a clini-

cal test that they should have anyway is much easier to talk to a family about than a treatment trial. [In the case of an experimental drug] that's a whole different thing. And I think some of the families really need to talk about it many, many times before they make their decision. (IXa p.8–9)

Finally, researchers observed that another possible motivation for granting consent might be that participation in research is one way that people connect with each other in order to make sense of their afflictions and suffering. In other words, participation in research is one way that people create community.

Many of them will say afterwards that we are doing much better now than we were doing 10 years ago. And the success rate now is built over the past ten year experience and they feel a certain obligation to those people who were transplanted 10 or 20 years ago to be able to do the same thing although forward. I don't know if they really believe it. Many of them say that it's important to them that the field continue to progress... There is a community of transplant patients. That's one of the strengths of our program that we introduce patients to people who'd been through it before. We introduce the [recipients] to previous [recipients] and there is a certain level of bonding, you are part of the same thing just like people who have survived cancer bond with other [survivors]. (VIIa p.6)

So there is [some] personal benefit [to participation in research], and though there are personal risks, there are also communities of patients. You know, around certain diseases these people know each other very well and I think they see a lot of benefit where that altruism comes in. They [can say to themselves] "I am also helping everyone else who has X, Y or Z disease". (X p.4)

Theme 4R Culture of research institutions

Researchers were keenly aware of the "culture" and politics of medical research and of the institutions in which they exist. How culture and politics shape the process of informed consent from the researchers' perspective was another core theme of the interviews.

So it's hard because even in my rôle, there is some incentive for me to get patients to participate. No [direct] financial incentive, but in a certain sense if we don't have any studies going on and no patients, then I don't have a job. So there is always like those little things in there. We want to have high enrollment for studies. I think that's really important. My boss is really

pleased that we have such high enrollment since we dedicated resources to it. So you kind of want to keep that going. I wonder how much that influences what I do and say to patients. (IXa p.10)

I feel like a kind of middle man because I am between the patient and investigator. The investigator has lots of valid reasons for wanting patients to participate and patients have lots of valid reasons for wanting to participate or not. Somehow we have to make these two match. Sometimes we have to help patients realize the goals of research are usually quite different than the goals of treatment. (X p.1)

I think you need a fair amount of narcissism, especially in this institution. It's part of the deal. There's also some amount of 'spin' [involved]. It's like high finance but in the academic arena. It's a game sense.... I was thinking: Can I do what is ethical? Can I do what is best for this patient? Can I ask intelligent [research] questions? Can I get this to happen—get people to give me my space, get my funding, get my resources and recruit people without being completely narcissistic? I'm pretty sure that I cannot [do all of these all the time]. So then I say: "How does one function in this realm? How can all these interests co-exist?" Or should we just let people do what they are good at and then find a way to work with that? (IV p.5)

Research and care are intertwined for both practical as well as political and economic reasons:

Another study we have is a treatment trial. Basically, in this one we are testing two drugs together. We are interested in getting FDA approval for use of the two drugs together even though each drug is already used off label. But we want to do a formal study so that we can give patients who do use the two drugs together a better idea of what to expect and what their side effects might be. Eligible patients can agree to be in the study or not. But clinically, we would offer them this same treatment anyway [because that's the standard of care even though it has not previously been systematically studied]. The investigator says, "Well you really should participate in the study. But even if you don't participate we'd offer you this same treatment [using both drugs]." That makes sense: We get formal data and everyone who needs to use two drugs benefits. But again, the patient always has a right to say no without reason. (IXa p.3)

That's a question I wrestle with all the time. Especially the trials where patients look at [research] as treatment and it's like, how much do you really want to drill into their head that really it's not treatment, it's research.

But if we really went to the extreme of saying “this isn’t treatment, this is research, would anybody do a trial? In a certain sense all of our research is treatment—because we are hoping to gain some understanding [in order to treat all patients better]. Otherwise, we wouldn’t bother. So it’s not like there is a clear line between the two concepts.... It’s not to say you would hide information from them. You present [what is known] as clearly as you can, but how much do you emphasize the ‘non-treatment’ aspect of it? (X p.11)

One of our [research projects] proposes that we have grants from three different agencies: One is for clinical care, one is for research, one is for safety. We actually propose that our main objective is to try and make it clear to the families that these are integrated. They are allowed to say no to the research studies but [the money] helps fund our center. And we wouldn’t have such good care for them if we didn’t have research. (VIII p.9)

Thematic Summary II (Subjects)

Transcripts of interviews with research subjects about what is at stake in informed consent were indexed according to a set of four core themes negotiated in an iterative process by the research team over 6 months during weekly research team conferences: (1S) “Motivations for participation”; (2S) “Experiences of the process of informed consent”; (3S) “Structure of the informed consent process”; and (4S) “Politics of Research.”

Theme 1S: Motivations for participation

Subjects spoke clearly about their motivations for participation in research studies. As researchers have also noted (see Theme 3R on page 11), “Altruism” was an important motivation evident in most interviews.

I believe they were going to use the same blood they had already drawn. It couldn’t hurt her and it could possibly help. Even if it didn’t—if she got placebo—it could still be beneficial to other people in the future, other children. That’s why we chose to do it. (A p.1)

To me it’s to think that doing this can be helpful to other people. To be helpful to them. Maybe they find that this new trial could even be more effective. And it definitely could not be worse. It just can get better and anything to get better.

I was just a little more selfish. I knew our son was in the high risk group from reading the literature. I was like, any potential help with very little risk against him

was an advantage. And like my wife said, obviously if it helps other people in the same circumstance, so it’s a win-win situation. (B p.6–7)

I’ve always believed in doing studies. I’ve always believed in helping others any way that is possible. That’s why I was glad to participate. I know, if I’m going to do this anyway, I have to come in this year anyway (for my check up), why not take an opportunity to make \$50 and help out kids who aren’t as fortunate as I was to have such good results.” (E p.4)

I suppose the good part is that you are able to make something positive of life, and in a way allow part of it to continue... I think that’s a way your body helps people.” (G p.2)

I’m sure half the things that were done to [my child] in her lifetime were a result of somebody else saying yes to research. My whole thing is, as long as it didn’t put her in any extra steps or whatever, why not? (I p.2)

Interviews with subjects often revealed the calculus of risks and benefits in which they engage as they work through the process of informed consent.

I’d get the tests anyway. I’d get the EKG, I’d get the ECHO. I’d get the stress test. I made \$50 by coming in. I don’t see any downside to this at all. It’s all benefit. (E p.2)

If there were risks I’d definitely have to think further about subjecting him to them. In this case, I felt that all of the tests were noninvasive. Blood [tests]—he doesn’t like them. But even that was an option. All of this [research] I think it’s very nice and I hope that something good comes of it. (F p.6)

I am always a believer. [My child] wouldn’t be alive today if it wasn’t for a lot of studies. And you know, [this is] a chance to contribute to that. Plus I think the research is really cool. And the deciding factor was that they wouldn’t even need to [do anything extra]—it wouldn’t hurt him in any way to be involved. There were no special tests. It was just information from his regular follow up care, you I guess, in a statistical way. And I mean, why would I want to say no to that, if that was me? (K p.2)

The other thing is that the research suddenly gets you [the attention of doctors]. My kid was on a special wing in a private room. There were teams of doctors coming in. There was a way in which it’s pathological, but it’s very flattering to be at the center of things when you are in research. And that is not to be underestimated. (C p.12)

It's like I told you. The studies that we have opted for are mainly a last ditch effort to do something to remedy the situation that we are in right now. We've never done anything drastic and nothing has ever been done for no reason. The ones we've done just made sense. We've either already done that and it's just a little bit more. Or it's something that may work. It's hard to say that anything we have done is really scary. Nothing was really that traumatic. (M p.1)

I think at baseline, the best reason to do that kind of volunteering of one's body for medical research when you are terminally ill is so that others can profit by it. In the religious sense there is a kind of 'profit motive' that is beyond the commercial... (C p.11)

Subjects spoke eloquently about other factors at stake in decision-making about participation in medical research. First, some talked about the importance of learning through participation:

I'm definitely down to do it because I want the hospital to learn everything they can from the study and be able to treat children who have what I had better, more efficiently... I'd like to know why." (E p.1)

I was just hoping that they would collect more information and benefit from it. Because I think research is important. It's the only way you learn something. (F p.4)

I would do anything to help or to participate in something as long as it isn't invasive for [my child]. How else are we going to learn anything. (I p.2)

Second, quality of life issues loomed large as subjects described what is at stake as they considered participation in research through the informed consent process. This was especially striking among subjects with serious, chronic and potentially life threatening illnesses:

After we weighed all that and how much pain he has already suffered [we said], ok maybe we should do this. We were at that point where you weigh which is worse. If we didn't have that pain, we probably would have said no [to research] because it wasn't worth the risk. You know, most of the time with a study, the drug is not FDA approved and we're kind of like guinea pigs. So it's always, let's weigh it and see... I guess that's quality of life. Which is going to be worth it? To get rid of the pain now so you can have some sort of life or worry about it later. I don't know. (M p.4)

It's kind of like we are in this situation [where] we don't have other choices and we want to make things better. So we do it... and we don't have a lot of options.

It's not like it's life or death but you are thinking "We can make this better if we try this [experimental treatment]." (L p.5)

It's not like basic money here. You know what's at stake. [You wonder] if a decision you've made [will] cause death or whatever. So we all know what's at stake. I don't know about you but I know betting on my life isn't something I'd do too easily. (Q p.7)

Theme 2S: Experiences of the informed consent process

Just as among researchers interviewed, many research subjects experience the informed consent process as an interactive relationship that evolves over time and within a social and emotional context rather than as simply a signed form that documents a one-way flow of information from researcher to subject regarding risks and benefits and required by administrative regulation. Availability of research staff during the process of decision-making as well as comfort with and "trust" or "faith" in the researcher-subject relationship were often mentioned as critical to the process of informed consent:

The most important thing is the availability of the staff to discuss questions, you know, to reason out and come to a good answer "yes" or "no". (K p.3)

I think we ultimately decided to participate because we had a lot of faith in the people we were working with. Although they answered our pointed questions, "what are the possible side effects or what have you, but I think my final decision was based on feeling comfortable with the people who, you know, are the medical professionals. (D p.1)

And so, yes, that sense of needing an interlocutor, it makes you spiritual in a way because suddenly you realize that "my mind is working but my body is betraying me." [One] needs some sort of agent to reconnect the spirit to the body, so that it's in harmony again. I think doctors are inevitably caught up in that sense of laying on of hands. It's intimate and therefore religious in the sense of literally tying together, tying the bits of ourselves together. ... [and] what's absolutely essential is that people feel that they are part of the process. They are not signing their lives away and consent isn't forced upon them. (C p.9)

Among research subjects the informed consent process was often discussed as an important aspect of the broader illness experience. Decision-making about participation in research was one among many critical decisions that helped in defining a larger illness narrative:

AK: What does [your daughter] think about being asked to participate?

Mother: She's very easy... This is her life. It's what she's been since she was two days old. She doesn't know anything different. Doctor's visits, surgery, that's just part of who she is. (I p.3)

AK: So you've been asked to be in a couple of studies?

[Subject]: Yeah, I have a special body... OK, It's just that I have some weird problems that most doctors can't figure out... I've got something. And I've been written up in two medical articles. That's always nice.

... So I'd say to other kids, go for it [participate in research]. It might make you a bit popular... you might get written up. (J p.8,11–12)

He's almost 18 now and it's important that we get his input... As he's gotten older he's become more mature and more involved in his medical situation... I mean in everyday life too. It's just his maturity. I don't know whether it's because he spent so much time at home in pain that his maturity level is so much higher than other kids. [So] he makes good decisions, I think. We met with the doctor and nurse and they explained to us the drug and what it did. It all seemed pretty good except that we wanted to look into the drug [on our own]. We got back to them and agreed that we would do it. We had to sign forms and everything. (M p.5)

[My child] was born with this disease and had to go through two transplants and everything else you can possibly go through... Yeah, it was a really bad experience but it made me smart... It made me ask questions and I stopped being afraid and intimidated by doctors. Because I saw how badly they could fail if you gave them blanket approval. And you know, I'll tell you, at Children's Hospital, it is its own world in and of itself. (K p.3)

I'm not real sure what I told [my twin children] about the whole process. I know that for them it is a life long thing. I don't know if they see research as something different. They have to do this anyways. I don't think we really explained much in a sense of it being a research project. They just know that they have to do it all the time. (O p.5)

Just as among researchers interviewed (see Theme 1R on page 9), some research subjects described how they were transformed by their experiences of informed consent relationships:

Well, OK. My decision isn't the only one that matters—though as a parent you are used to thinking that way. It helped me realize that as [my child] is growing up he needs some space and freedom to make his own decisions. It made me re-evaluate my whole way of parenting him and the whole way I was advocating for him in the medical situation. It was just the eye-opener that I needed. (K p.6)

We become geniuses on our child's illnesses. We become sort of idiot savants overnight. And I think that's regardless of education, regardless of whether you can express it grammatically or not. That's just what happens. (C p.3)

Finally, research subjects often reported that experiences of illness and of informed consent forged a sense of community among them. The importance of creating community was also reported by researchers (see Theme 3R on page 11). In many ways the meanings of informed consent and of the illness experience were mutually constructed:

AK: So if you are in a study now where there are lots of other kids who have the same thing, what's that like?

RS: I don't know. It's weird. Not weird in a bad way but weird in a good way. So I don't have to feel left out. (N p.3)

In the waiting area you become like family. People come and go so we make many friends. Everybody supports each other, they are just wonderful. And the family room is wonderful because it gives people an opportunity to come in and share their stories, their experiences. Like I said, when you think you are at your worst, there's always somebody there who can say they have it worse than you. You can always meet somebody in the laundry room who's been battling something for years and years. We've only been here for six weeks [undergoing treatment and participating in research]. (A p.4)

[With informed consent] we like to be able to talk it over, weigh out pros and cons, then be able to go and ask more questions. Another thing that is helpful is to [talk to] previous patients that have had similar medical issues. As a parent sometimes it can give you a little bit more information. It gives you a sense of what the future might hold. (P p.9)

If one has that kind of altruism, that sense of being almost tied together as religious motive in the best sense, [what you are doing with your body when you participate in research] you are doing for the community [of other sufferers]. (C p.11)

Theme 3S: Structure of the informed consent process

Valued Qualities. Research subjects expressed a clear picture of what qualities they value in the process of informed consent as did researchers (see Theme 2R on page 10.) Among these, the process should emphasize the “voluntary” nature of participation (B p.9, M p.2, C p.10), be presented in a “clear,” “complete,” (M p.3) “calm,” (K p.4) “open and honest” way in a “comfortable place” which is “private” and with “no pressure” (B p.9, B p.5, I p.6) applied. To quote one parent:

“that’s always a bit routine or clichéd [but]...you really do have to get to a spot where you don’t feel pressured because so much with these sorts of decisions...hangs on them. (C p.11)

Communication. Nearly all subjects pointed out the importance of communication in the process of informed consent. To quote one respondent: “Communication is huge”. (P p.8) Overwhelmingly, respondents indicated that the researcher obtaining consent must “know the audience”. (I p.7) In other words, the researchers’ tone, vocabulary and level of discussion during the informed consent process must be appropriate to the audience. (B p.11, E p.5–7, G p.11, I p.5–9, J p.4, M p.11)

Moreover, some spoke out forcefully against communicative approaches to informed consent that hinted of “sales pitches” or that seemed like “commercial transactions.” The process should feel like “an invitation” (B p.9) and “doctors should have manners” (I p.9)—be courteous and respectful in their communications with research subjects.

Timing. Many research subjects mentioned the ways that “timing” made an impression on their experience of the process of informed consent. Sometimes the acuity or complexity of a specific health circumstance and its emotional impact complicate families’ abilities to engage in that process comfortably. In these situations, the importance of families’ social networks and relationships between subjects and researchers become especially critical.

We were asked to participate the day before her surgery. So we were kind of numb because it was like a ton of bricks to us. This didn’t happen to our child. But when they came by to talk to us, they just explained.... I really didn’t have a problem with the way we were approached to begin with. They asked if it was alright before they even approached us. I guess they wanted to make sure it was a good time. (I p.5)

Sometimes you don’t want to be included because it’s too much. But other times you want to know what’s

going on [with research]. I guess it’s the timing. (I p.10)

We were given a lot of information at once. So that was something in itself to absorb. We were at the same time, or not too much later, told about the study. We were given some paperwork to take a look at, to sign if we were interested in participating. We were given the opportunity at that time to ask some questions but I must say, there was a lot of information being thrown at us....Being lay people, we didn’t know enough appropriate questions or concerns to ask a lot of intelligent questions... But I think ultimately we decided to participate because we had a lot of faith in the people we were working with. (D p.1)

When you are under pressure or stress, words flow over your ears like rushing water. There was an [informed consent] form, but I couldn’t even see that. I needed to be separate for a little while. And that brings up another ingredient which is time. I don’t know how you take care of the issue of time, but it should be considered if at all possible. [You need time to consult with friends and to gather your own information]. (C p.3)

Understanding. Almost all research subjects pointed out “understanding” as a key aim of the informed consent process. As previously noted above, this topic is elaborated in the “Discussion” section on page 21). From their perspective, this aim is difficult if not impossible to achieve though it is best approached by asking questions:

You need to be fully informed about what are the risks for yourself and your children. [Yet] I don’t think you can ever be fully informed. There’s always going to be a question. (D p.5)

Moreover, for research subjects, “understanding” is best pursued as a two way process—an interactive exchange between researchers and subjects:

Ultimately, one “understands” when the reasons, motivations, and expectations of the research in which one is engaged are discussed and grasped:

I think from a child’s perspective it would be better for them to be able to read the reasons why they are doing a study and what they would like to achieve, as opposed to an adult who gets to read about so and so who is doing the study and that all your rights and privacy are protected. Yeah, so what? Somebody has to help them think through the process... Why are you doing this and why me? And I know that is the question that every child in this hospital is asking “Why me?” If you can make it into a positive because “maybe if we

can talk to you and we do this research we can change things. Do good changes, positive changes. That's why we are talking to you. And also because you count." (G p.5–6)

Understanding is about figuring out how they are going to hear what I am saying. To inform someone is to let them know they are being included. (G p.10)

Engagement of the Child. Most research subjects and their families expressed strong ideas about the importance of engaging young people in the process of informed consent. To a very great extent they portrayed inclusion of the voices of subjects as a force for strengthening and sometimes even transforming the informed consent relationship in profound and positive ways. On the other hand, when subjects are excluded from the conversation, they feel alienated from the process of informed consent and disaffected by the experience of research.

I do bring her into the decision-making process. I have for a long time because I think it's easier for anybody to accept what is going on and be comfortable with what is happening if they know why it is happening... This is really her life. (G p.2)

One time that I didn't tell her something [about participation] she got really upset with me and said, "You know, Mom, It's my body and I have a right to know." (I p.3)

I guess I'd have to take [my son's] lead and say that you have to involve the patient. Even if the patient is a minor, he still needs to be involved, maybe everything explained to [him] at [his] level, whatever that level is. I don't know... I've noticed that if people ignore him and his concerns, that's a reason for him not to like them. It doesn't just go away, that's always there: "That person ignored me." (M p.9)

Ask the kid mostly. Because, like, it really depends on family structure, how everything works in the family. But let the kid know that [he] has a choice in it, too. At least try to. (J p.4)

Something that frustrates me beyond belief is that I'll ask a question of one of my doctors. And when he replies, even though I asked the question, he speaks in the direction of my mother. That's something like when a witness looks at the judge. I asked the question, so look me in the eye. I think that's the one thing I would like to change all around. [Sometimes] I have to say, "OK, [look], I'm over here." (L p.6–7)

INT: Do you have advice for researchers about how they should talk to kids?

Subject: I guess they could just ask basic questions like you were asking me... I think we should be included in the conversation. (N p.4)

Talking to kids is important because you are allowing them to know you value their opinion and their opinions are going to make a difference. It is not just another blood test or X-ray or any other kind of test that is going to get stuck in the pile someplace and who cares. (G p.6–7)

Just because I don't have an M.D. after my name doesn't mean I want you to explain everything to me as if I were a dummy. You know how they have those books, 'Golfing for dummies,' "wine tasting for dummies." I think too many doctors feel they need to be the authors of those books when they talk to patients. (L p.3–4)

Theme 4S: Politics of research

Some research subjects offered insights into the politics of medical research as they reflected on their experiences of informed consent. Their perspectives on how the interests of researchers and research institutions shape the process of informed consent are few but trenchant and captured in the following examples:

There's definitely doctors out there trying to gain notoriety through stuff [like research]. And depending on their morals, what will they do to get it? It's just like there are good ones and there's bad ones. Just like in any other profession. People are always talking about doctors this, that and the other thing. But they are just people. (B p.14)

Researchers are not in such a big hurry all the time... And [their work] is for a whole different purpose. It's not about making money in the same way, you know, "Gee, if I do that many catheters today, I'll make that much money." And the researchers are just a whole different breed of doctors anyway... They are all about the beauty of the knowledge. It's that they are after the apple. (K p.11)

Informed consent is a sub-species of contract. And a contract involving consent is always the most difficult form because it's a fiduciary relationship. And contracts with fiduciaries are always subject to the vulnerabilities of emotion involved. [In addition] you're dealing with something where there are no guarantees and yet the contract is a form. These consent forms are designed to ward off litigation. They are not designed to protect the people in question. And because there are no guarantees, what you are really doing is warranting

[the researcher and the research institution] against a particular outcome. And I'm not sure that's always clear to people when they are signing the form. They think of it only in terms of permission. What this is really about is not permission. It is about warranting the doctor [and hospital] against a lawsuit for a range of unpredictable outcomes... So how do you communicate that to somebody? [It's difficult] because [if you did], nobody would ever sign it. (C p.4)

Where [the politics] becomes most troublesome is with people who are desperately ill... Where it is really life or death, my sense is that it is an extremely difficult line. I mean, I really have personally a lot of problems with the kind of human engineering that is being done now because I think the line has moved a lot in recent years, largely under pressure from pharmaceutical companies who want to recoup investments and who use payment as an inducement. And so the bodies of the very poor get transacted upon. And it's purely commercial... (C p.11)

Thematic Summary III (Policy Makers)

Fieldnotes of interviews with IRB committee members were indexed according to three core themes uncovered by the authors: (1PM) What is informed consent?; (2PM) Administrative Challenges; and (3PM) The Politics of Informed Consent.

Theme 1 PM: What is informed consent ?

Policy makers were unanimous in their conceptual framework for understanding the conflicting meanings of informed consent. Many pointed out that informed consent is both a legal document and a relational process that unfolds over time.

The IRB views informed consent as a formal document. Unfortunately [this document] has very little to do with the actual process of communicating with the family and either enrolling or not enrolling them in the study. All of the time in the IRB is focussed on the wording of the informed consent document... In many ways informed consent is a legal process. In the IRB we serve to try to achieve the letter of the law, not necessarily truth or justice. (AA p.2–3)

Everyone knows that informed consent is not really a piece of paper. Yet on the other hand, it is a legal document. So a lot depends on the researcher's attitude. And the way he presents the legal document matters a lot. (GG p.1)

A lot of times participation in a study is a long process. It doesn't take place at a single time. The informed consent document doesn't permit or capture the fact that there is a prolonged give and take. (AA p.6)

Theme 2 PM: Administrative challenges

Policy makers pointed out some of the difficult administrative challenges that emerge from conflicting meanings of informed consent. Moreover, interview and fieldnote data reveal that policy makers also recognize how competing stakeholder interests sometimes require the privileging of particular meanings above others.

I've been part of the IRB for [many years] and what I know is that the administrative changes [have become] painful. (AA p.1)

The lengthy forms are intimidating for families. From the number of pages to the level of detail, I'm sure this must be overwhelming for [subjects]. And HIPAA only makes matters worse. It doubles the number of pages and makes them even more unintelligible to the researchers themselves not to mention the potential subjects. To me [they] are really complex legal documents. (CC p.5)

Since day one I have felt that the informed consent satisfies institutional, regulatory interests. It satisfies the guidelines. But we have no idea whether and how a family understands what is there. It's so complex. And it really has become more of a legal document than a tool for explaining to subjects what the study is all about. So most of the time families just say, 'Where do I sign?' They don't read it and I don't blame them. Sometimes I don't understand the forms either. (DD p.1)

Historically, there has been an adversarial relationship between the IRB and researchers. Of course, I never felt that way. Regulations are very important, though not everybody's into them. (HH p.1)

Theme 3 PM: Politics

Often, policy makers identified a simple remedy to the problem of lengthy forms. As one put it succinctly: "You need to ask in plain language". (DD p.2) Nevertheless, the broader regulatory, bureaucratic and legalistic discourse about informed consent that rules the day in the current cultural and sociopolitical environment leaves few opportunities to enact this simple remedy and to do what makes most sense with regard to protecting subjects and engaging them in ways that promote understanding. From the policy makers'

perspective, struggles over contended meanings are the essence of the “politics of informed consent:”

Researchers think that the IRB should be there to help them. And though usually there is common ground, the IRB has a different function... They're ‘the police on the street.’ And people feel intimidated by police. A conflict arises because the researchers see themselves as trying to come up with better care as they advance their fields. And they see the IRB as trying to control

them. But the researchers feel they don't need policing. So there's this political struggle. (AA p.1)

The problem is that the forms have become ridiculous. It's hard enough to understand the medical issues. And under pressure from the Feds, the administrative burden and complexity of the forms gets heavier and heavier. They just keep adding and adding. The push is for more and more regulation. (DD p.2)

SECTION 4

Ethnographic inquiry into the experiences of informed consent reported by a range of stakeholders—researchers, policy makers and research subjects—yields unique insights into a major contemporary social enterprise, illuminating the interests at stake and a range of conflicts that hold the potential either to strengthen or to put at risk the mission of protecting research subjects.

The present study reveals three co-existing cultures at work in the fieldsetting—the culture of research subjects, the culture of researchers and the institutions they work within, and the culture of the policy makers, (*e.g.*, Institutional Review Board members) mandated by law and tradition to mediate between the other two. Each has different rôles and routines of everyday practice, different experiences, uses of language, and interests at stake within the social institution within which informed consent takes place.

Our study shows that all stakeholders recognize the multiple meanings of informed consent. Nevertheless, for historical, social and political reasons, the prevailing “official” discourse of informed consent is legalistic, bureaucratic and technical (defined by administrative interests within institutions), regulatory (characterized by written rules and policies and means of enforcement), and textual (based on written forms and policy guidelines). A great deal is at stake for health research institutions to ensure that the “official” discourse is both correct and complete. Severe consequences ensue for any institution that does not adhere to the formal responsibilities and obligations imposed by official regulations (for example, see the New York Times, 05/25/99, “In Tests on People, Who Watches the Watchers?”)¹

While the “official” discourse on informed consent serves to privilege and amplify the interests and practices of certain stakeholders, it mutes or silences the others. The current study uses anthropological methods to reveal and recover what is at stake in informed consent among researchers and research subjects whose voices have become marginalized by the “official” discourses.

¹ The economics of the research enterprise profoundly raises the stakes for many institutions. For example, federal regulators suspended Duke University’s license to conduct research involving human subjects because of violations of ethics and safety policies (some of which involved informed consent forms), and all 2000 research experiments were temporarily called to an abrupt—and expensive—halt.

DISCUSSION

What’s at Stake?

Stakeholder interests are sometimes in conflict. Tensions develop between the different parties:

The IRB has a different function... They’re “the police on the street.” And people feel intimidated by police. A conflict arises because the researchers see themselves as trying to come up with better care as they advance their fields. And they see the IRB as trying to control them. But the researchers feel they don’t need policing. So there’s this political struggle. (AA p.1)

That’s because it [participation in research] isn’t just ‘altruism,’ it’s really more like enlightened self-interest. (VIII p.6–7)

The data also show that researchers and subjects are not necessarily passive participants in “official discourses” on informed consent. They can (and do) articulate and exercise their own agency in the everyday practices of informed consent, showing a considerable capacity to make decisions and to take action both in their own interest and in the interest of others. This agency is often expressed in the form of resistance to the official discourses on informed consent. For example, all researchers interviewed in the course of this study recognize and satisfy the bureaucratic obligations imposed by the IRB and have made very sure that the subjects they recruited both read and signed the informed consent forms. Nevertheless, they are unanimous in their critiques of the complexity, length, and alienating aspects of overly legalistic texts that often confuse rather than “inform” the very subjects that these forms were apparently designed to “protect.”

I’d rather just chat to them about [how to make the decision to participate or not]. The paperwork is an impediment. It gets back to where we started. Paperwork sometimes becomes an impediment to understanding. (VIII p.8)

The most striking critique of official discourses of informed consent is to be found in the everyday practices of researchers and subjects. The central finding of this study is that the meanings of informed consent among researchers and research subjects are fundamentally *relational* (interpersonal and social), *experiential* and *performative* (*i.e.*, what people know directly through their own senses, and do with their own minds and bodies in everyday practice), and *processual* (*i.e.*, unfold or happen over time). From the perspective of researchers and research subjects, meanings emerge from what is said and done as people interact in health research

and care institutions. From the “native’s perspective” (speaking ethnographically), these meanings are as real and as powerful in shaping their experiences of what is most at stake in their day-to-day lives and work as any written rules or policies of the “official” informed consent discourse.

Research subjects also expressed politically sophisticated and strongly held opinions about the “official” discourses of informed consent:

These consent forms are designed to ward off litigation. They are not designed to protect the people in question. And because there are no guarantees, what you are really doing is warranting [the researcher and the research institution] against a particular outcome. And I’m not sure that’s always clear to people when they are signing the form. They think of it only in terms of permission. (C p.4)

And yet, these same research subjects also suggested practical remedies for the problem of conflicting meanings of informed consent:

What’s absolutely essential is that people feel that they are part of the process. They are not signing their lives away and consent isn’t forced upon them. (C p.10)

In short, informed consent is both a thing (*e.g.*, a text) and a set of actions experienced and interpreted by people who interact in the community that constitutes the field setting. In practice, signing the informed consent form is merely one moment within a far larger and more complex web of relationships and experiences that unfolds during the process of informed consent.

Moreover, the agency and resistance of researchers in the process of informed consent explains the strong but still emerging backlash against the power of IRB committees evident in several recent publications (Warlow, 2004).

Notably, this study shows that even some IRB members—who may be responsible for adding to the complexity, length, and, dare we say it, imponderability of the forms—are often keenly aware of, and frustrated by the burdens and limitations of the “official discourses” of informed consent:

The lengthy forms are intimidating for families. From the number of pages to the level of detail, I’m sure this must be overwhelming for [subjects]. And HIPAA only makes matters worse. It doubles the number of pages and makes them even more unintelligible to the researchers themselves not to mention the potential subjects. To me [they] are really complex legal documents. (CC p.5)

‘Understanding’ in the informed consent process

Conflicts are essentially a struggle over interests and meanings. Ethnographic inquiry reveals, for example, that “understanding” is a key aim of the informed consent process. Yet among the various stakeholders with different interests, there are also different meanings of “understanding”. Ethnography is a powerful tool for revealing this diversity of meanings and interests.

Recognizing the different meanings of understanding, and the ability to navigate among them, are critical activities that are fundamental to the process of informed consent. For families, this understanding often involves gaining insight into a very different world—the medical culture—as well as remembering and making sense of just how and why they became part of that world. For researchers, understanding involves communicating the essential information that they think families should know—*e.g.*, the risks, benefits, purposes, and commitments involved in research participation. For IRB members, understanding means that the subjects and families can rationally recall the facts that were spelled out in the informed consent document.

What is in the word ‘understanding’?

To the research subjects in our study, understanding is more than mere words and language; they see it as a process of engaged involvement between researcher and subject, tailored to their own particular interests, needs, capacities and circumstances. This has particular implications for children, as one parent pointed out:

Some people have more patience [with children] and are better able to think of [how best] to phrase an answer or a question or a statement [so that they understand]. (G p.10)

Among the research subjects, understanding is a two-way learning process. Being informed involves their being made aware of the facts of participation, as well as “letting [child subjects] know they are being included” (G p.10):

You can’t expect a three year old to be able to really comprehend but I think in her own way, just understanding that it wasn’t something that was being done to her, that she wasn’t being hurt without a reason, and that ultimately there was a benefit. I think [inclusion] is really important even for little kids. I always get very annoyed when I see people talking down to small children. There is something that isn’t working. (G p.2)

Researchers emphasize that understanding evolves over time. It is important to them that informed consent is an

ongoing process, not merely a single event or the signing of a document. The experience of being informed requires tailoring to the needs of the subject, requires time to be made for subjects to deliberate and for the subjects to be provided with sufficient ongoing access to the researchers.

For me, all patients, at all levels must understand what the risks of the test are, what the concrete discomforts are, but not everybody has to understand how the machine works. Again, for most parents, they are operating at the level, “could it hurt? Could it have any long lasting consequences? (I p.4)

Extremely sophisticated patients can make extremely sophisticated decisions about cutting edge and they don't need any doctor. They come in and say, “I want this.” And the consent is just a formality because they want it and they don't really care what I am going to tell them. Unsophisticated patients, the worst thing that can happen is that they trust a doctor because he is a doctor and go for something that isn't really right for them. Somehow you have to make it clear that there might be some risks for them. I guess it's in presenting the alternative. (VIII p.8)

But understanding is difficult because it is hard to know if somebody understands you [or if] families just want to please you. I think it's important to ask quite few times if families have questions, if they need anything clarified (IXb p.1)

We want them to know that informed consent is a moving target. So, their sense of being informed is going to change over time (VIa p.6)

It's imperative that the people understand what the research study involves for the patient but they can understand it at different levels of knowledge. (I p.4)

It's really important that they really do understand what it is that they are about to do.

I think that's it. Just to make sure they take their time, they review it they answer their questions, they think really thoroughly about it and that they are really comfortable with it. (IXa p.9)

Competence in obtaining informed consent requires a keen sense of “where parents are ‘coming from’.” Mastery of the process of engagement is part of the challenge and artistry of informed consent:

And you might start out also with one concept of where the parents are coming from and discover in the iterative process of the consent that their level of understanding is way higher or way lower that you thought. And so, I think the informed consents are challenging.

It's challenging to feel like you did the best you could for each patient. (I p.1)

I just think it's being empathic. I don't have a full knowledge of what they are going through but I can really see... the tip of the iceberg of what they are going through so I just try to let them know, that I can see just a little bit of what they are going through. (VIIb p.2)

Among researchers, understanding—which, from their perspective, is the point of deliberation—also requires that the subjects grasp the purpose of the study:

Well, I'd like them to understand mostly what the important question is... What I think most important is they understand what we are studying and why we are doing it. (VIIa)

The “two-way” nature of understanding from a “practice” point of view is made quite evident in how the researchers spoke about the ways they assess interactions moment by moment during the informed consent process:

If I wasn't comfortable with them understanding what the study means, then I wouldn't continue. But it's in the first 15–20 minutes after explaining to them what the study is, what it means to their family, what are risks and discomforts can be and what the benefits are [that are so important]. It's also crucial to make sure they know it's a voluntary thing. And you have to give them room to ask questions. If they feel comfortable at that point, then I think that's the first step of informed consent. Like I said, it's a process. (V p.7)

[These are] the only things I can think of: questions, comments, and kind of facial expressions they have—like if they nod. They [might not] say anything, but you can still get a sense of whether they kind of grasp it. (II p.4)

From recall to remembering

The “official,” regulatory discourse on understanding in informed consent typically emphasizes what facts the subjects can recall from a written document: *e.g.*, what is the purpose of the study; what are the risks and benefits. There has been recent interest in what and how subjects recall (Stenson *et al.*, 2004). But among the subjects in our study, the recall of facts was only a part of the understanding that they felt took place as they interacted with researchers over time. In other words, the subjects remembered more than just the facts, and this prompted them to talk about the social and emotional context of informed consent—what was going on before, during and after the signing of the written document.

Often during interviews with research subjects, a critical moment of remembering experiences in which informed consent was obtained around a serious illness, would be accompanied by tears or other markers of deep emotion. For example:

I think everybody [who has benefited from research] wants to give back. Maybe [I feel this way] because [my son's] outcome was good. But if I knew then [laughing] what I know now [18 years later], I would be ever so wise. I had no idea. [Subject begins to cry]. I'm sorry. It's just a roller coaster. You just don't know. What's that saying: 'Life is like a box of chocolates. You just never know what you are going to get.' (E p.6)

Pivotal Moments

The process of informed consent is also characterized by pivotal moments. Here, multiple interests and contested meanings are negotiated between the stakeholders. At pivotal moments, the balance of authority shifts, and relationships between stakeholders are transformed.

Oh, my gosh! He transformed! He was transformed. I think partly, being able to talk... basically he said, "I still don't feel like I want to release my information." And "that's fine, it's totally voluntary, you don't have to do this. He became a teacher... (VIIb p.11)

What does it mean to listen to what has been silenced? To really hear what is at stake for potential subjects as they decide whether or not to participate in research? The "Case of the Boy Who Said No" is one answer to these questions. First, it was striking that a child exercised his own agency and autonomy by saying 'no' to participation in research at a moment when his parent had already agreed on his behalf. What was especially remarkable in the case was that both researchers and policy makers acted to protect the young subject by listening to him and taking his word and point of view seriously. From the researcher's perspective, it became a "pivotal moment", and for the parent it was no less of "an eye-opener". The experience of that particular informed consent process came back in vivid detail as each spoke about what was most striking and reflected on what they learned, and other researchers resonated with the importance of learning from challenging subjects, *e.g.*: "It's more when people don't participate that I learn from them... The ones that say 'no' stand out," began the researcher as she recalled the experience which still stays with her. In the words of the P.I., "Never before did we have a parent say: 'yes,' and the child say 'no' in something that is, as sort of non-significant as [this] was."

In this particular case, researchers, parent and child alike were shifted out of their familiar rôles to discover what was at stake for each. They moved from simply assessing facts, *e.g.*, "he needs the drug any way," and "I'm the parent who decides...", to acknowledging and addressing the subjects' concerns:

...Especially when it comes to chronically ill children, they have so very few options, and such little control over their world, that when you can give them the power, you should, even if hurts the study. (K p.13)

A careful consideration of pivotal moments can be very productive (Katz and Shotter, 1996) since they frequently illuminate what might otherwise go unnoticed. In the case of the boy who said 'no', both researcher and parent were struck by the child's saying 'no' to what was previously seen by the PI as "non significant"... a matter of fact. In the researcher's words, each stakeholder was transformed by listening to the subject. "They took mine over my mother's", the boy said, "that was as a surprise!" Yet there was 'the more': "he became a teacher," said mother and researcher alike. In conversation with each, further elaboration and refinement illuminated new possibilities for practice and for 'going on': "It changed the way we do informed consent" said the researcher: "We now always include the child".

Moreover, the experience made more visible taken-for-granted-notions of parenting. The boy's mother saw the episode as the sign she was looking for: that her son was ready to take on more responsibility with regard to managing his own illness.

This case is an example of how relational aspects of the process of informed consent can transform the participants: parents, children, researchers and policy makers. What are often experienced as separate cultures can also be understood as intersecting realms of action with the capacity for the transforming and benefiting all stakeholders.

What emerges from this exercise is a portrait of informed consent as a dialogic process in which all stakeholders can fruitfully engage. Inspired by the preeminent scholar of informed consent, Jay Katz, we move from what has been the silent (or silenced) world of the subject to hear the voices of all who participate (or choose not to participate) in medical research. In effect the potential exists to move from a monologue of disclosure to a true dialogue (Katz, 1980, 1984, 1998)—from merely assessing 'information' to supporting the 'participation' of all relevant actors in the research process.

Listening to the concerns of the research subject has led to innovation in informed consent in ways that strengthen relationships central to the social process.

Informed Consent is Relational

In this study, our approach to the fieldwork has been marked by a special kind of dialogue—one that invites mutual inquiry—in which family and researchers were invited to articulate and elaborate their concerns and experiences. We responded dialogically to *their* ideas and what matters to them, rather than imposing upon them a series of monological solutions of *our own* professional devising. These meetings *made visible* (in the sense of allowing them to be voiced) values, questions, and moral dilemmas that would otherwise pass by unnoticed. In this intersection of the different ‘worlds’ of families and researchers, each offered advice and suggested new possibilities and procedures that might enhance the process of informed consent. These are presented below as major findings, recommendations, and areas of concern.

Major Finding #1: The key stakeholders—patient/subjects, parents and researchers—all see informed consent in *relational* rather than regulatory terms, *i.e.*, the process involves the gradual creation of a multi-dimensional relationship, whose strands evolve over time. It is not, and cannot, be a single contact that ends when a consent form is signed.

All participants suggested that the process works best, that tensions are reduced, that patients are most protected, when informed consent is much more than a “meeting of strangers,” when it gives rise to an engaged involvement among all concerned. This kind of *involvement* only occurs, however, when the subjects’ voices are heard, when researchers are accessible for additional questions and concerns, and when they are attentive to the context—particularly to issues of timing in acute settings, and of responsiveness in high-stakes and chronic situations.

Major Finding #2: Parents, subjects, researchers, and IRB members revealed a detailed knowledge and subtle understanding of the informed consent process, as they became involved and engaged in our research interviews and as they reflected on their serious concerns about the actual conduct of the process.

These findings form the basis for our remaining conclusions. Our first, and most important, recommendation will be further elaborated in subsequent more detailed recommendations and concerns. It can be stated as follows:

Major Recommendation: The IRB should continue to foster the atmosphere of mutual inquiry and dialogue among all stakeholders begun in this research, and move to legitimize the *social* aspects of informed consent by: a) developing “informal” or “unofficial”, as well as formal, official relationships between researchers and the clinical investigations office, and b) by working to reduce those circumstances that are overly bureaucratic and which get in the way of relationship building.

The other recommendations are organized around navigating the different ‘cultures’ at Children’s Hospital: a) between IRB and researcher, and b) between researcher and family subjects. The specific recommendations that emerged from our study have been further broken down into various sub-categories: those for researchers, for families, and for the IRB. Within these divisions, we also discuss the factors that impede a relationally responsive informed consent process.

Navigating different ‘worlds’, interests and meanings of families, researchers and IRB

From the data, we can begin to sketch out *the scene of an ideal informed consent process* with sufficient time allotted for several conversations, and for all participants to come to an understanding of what is at stake in decision making, and how it is being evaluated from each other’s point of view.

Because our study was situated within the practice of informed consent as part of the research process, it made visible the ability of many researchers to make sensitive judgment calls, to acknowledge the context of what was at stake for the families; to see informed consent from the multiple views of all participants. In navigating what is at stake for multiple participants, the practice of informed consent is not a simple input-output model, but one that must rely on judgment, trust and flexibility for the protection and regard of human subjects.

In this intersection of the different ‘worlds’ of families and researchers, each offered advice and suggested new possibilities and procedures that could enhance the process of informed consent which are described in detail below.

Collaboration

An over-reliance on external procedures can contribute to an atmosphere of tension which would constrain the researchers, however well intentioned, from tailoring their approach to particular circumstances.

Recommendation #2: To promote flexibility within the informed consent process, it is important to demonstrate trust in the researcher's judgment, rather than adopt what has been characterized by some IRB members as a "heavy handed" regulatory approach.

Enhancing opportunities for creative intersection between 'worlds' of research and clinical investigations

Recommendation #3: "Informal" contacts are important; they build the capacity for responsiveness. It is important to recognize the "unofficial" aspects of interactions between researchers and the CCI.

Our findings include accounts of researchers who have contacted the Committee on Clinical Investigation (CCI) with questions, and of subjects who call with concerns or "complaints". While each "culture" may see a dilemma differently, it is only after acknowledging what is at stake for each—researcher, parent, child and IRB—that fresh solutions can be found. One member of the research staff still talks of how helpful the CCI was when she was faced with a challenging situation.

This level of responsive attention became part of a larger transformation of rôles and creation of new practices that enhanced the informed consent process. In such cases the CCI can function as a relational resource, navigating the concerns of each actor in this local moral world (Kleinman, 1995), rather than as an instrument of surveillance. "They didn't make me feel like a Neanderthal," said the researcher, "And we all learned a lot."

Recommendation #4: Recognize and reward those innovations by researchers that enhance the informed consent process.

In the course of our study, we learned of innovations by researchers and PIs that enhance the consent process which developed in *response* to particular circumstances. One department offered the option of audio-taping the informed consent meeting to families whose first language is not English. These families found it very helpful to be able to take the audiotape home to review it on their own, or with trusted supports. This practice was so well received in that particular department that it has been offered to other families *as an option*. In another department, researchers have chosen to include informed consent as one of a series of ongoing family meetings. Other researchers found it most useful to include the informed consent in a joint meeting scheduled in advance (see "Families recommendations for families" on page 30) with both research nurse and PI

present so that each could provide relevant information from their own perspective.

It is crucial to recognize that these new practices developed *in response* to what was important to families; they were not imposed externally. They could be considered as "naturally occurring resources" that can be modified and elaborated according to the particular circumstances. We emphasize that we are not suggesting that any particular innovation be replicated; it is not something that should become the next regulatory requirement, quite the opposite. What is important is to encourage an atmosphere in which researchers would feel sufficiently trusted to share such approaches as part of an ongoing dialogue about the process of informed consent.

Continuing the dialogue

Recommendation #5: To continue the dialogue among multiple participants that began in this study, it would be useful to invite the participants—researchers, families, and IRB members—to be involved in ongoing, structured 'meetings' with the various stakeholders. This might start with an initial 'mini-conference' for discussion of the present report among researchers and family members where the major themes and recommendations could be presented and discussed, and suggestions for the next steps invited by the authors and others. Suggestions might include, but are not limited to:

- participation in monthly meetings about the process of informed consent. This would be a different kind of "challenging case conference" in which the various departments would informally present dilemmas, conundra, or innovative approaches to enhance the informed consent process. In such a forum, innovative suggestions might be prompted by discussions of enhancements that the participants might otherwise either take for granted, or not say out loud for fear of more surveillance.
- an annual or twice-yearly retreat for IRB members, researchers, and family members who have participated in research.

It is important to recognize that if the choice is made to include multiple stakeholders including subjects and families in follow-up meetings, a period of *preparation* will be crucial to permit each group to participate effectively in such an unfamiliar kind of meeting so that everyone's concerns can be heard and understood. These meetings must be facilitated, *i.e.*, there must be an ongoing process of preparation, helping all concerned to enter into the different 'worlds' (Katz *et al.*, 2000)

Recommendation #6: Informed Consent is a practice and, as with any practice, it requires development and attention if it is to be performed well. Some PIs and researchers drew the analogy between gaining competence in informed consent and how medical students learn about diagnostic interviewing. They suggested a faculty development program in interviewing for informed consent.

Issues in existing relations

Between IRBs and researchers. The words come from one IRB/clinician researcher; the sentiment, however, is echoed by others:

Conflict arises with clinical investigators [because they see themselves as] trying to come up with better care, advance their fields. The IRB is cast in the rôle as controlling [clinical investigators]. Sometimes clinical investigators get the message that the IRB doesn't trust them; sees them as unethical. (AA p.1)

The dilemma with PIs is that they view themselves as good guys, trying to make sure the family understands everything. To know whether they do that we'd have more policing which would surely be more intimidating and offensive to clinical investigators.

The challenge inherent here is how to create a culture of collaboration and flexibility rather than one that is regulatory and seen as 'policing'? How to build on or develop this capacity for tailoring and judgment; to be sensitive to certain situations without presenting another level of constricting regulations? How to foster the flexibility to attend to the concerns of a particular family?

Recommendation #7: Creating an atmosphere of respect for the judgment of researchers helps to enable a process of mutual learning about what works and what doesn't in informed consent. Each culture has a different definition of what is a problem; exchanges among multiple perspectives would be useful to enhance informed consent as a collaborative process.

Between researchers and families. An IRB member accurately portrays the nature of 'meetings' in the hospital setting. This is most intensified in acute settings such as the ER, and in acute circumstances, e.g., coinciding with a recent diagnosis:

"With the investigators, the M.D.s, this is their everyday environment. They've chosen it. They're comfortable; it's their world: blood draws, MRIs. They live in a world where it's natural. They lose track with the experience of the person who's bringing their kids in".

"[People come in from the suburbs, fight traffic. They get into the urban environment] By the time they get to the parking garage they're totally frazzled. It's totally confusing—insurance forms—people coming at you from every direction." (GG p.2)

Since this is principally a matter of "timing", we shall defer our recommendations to the more detailed discussion in the "Time" section on page 28.

Between families, researchers, and the IRB.

Recommendation #8: Include less technical writing in Informed Consent forms, and for children, place more emphasis on the purpose of the study.

The families recommended that consent forms should not only contain "less technical writing" but, for children, should emphasize the purpose of the study, so they would know what they would be contributing to: "Especially from the child's perspective, it would be better for them to be able to read the reasons why they are doing a study and what they would like to achieve." (G p.6) Statements could be inserted into the consent forms such as: "This study is aimed at answering the question...", "The reason this is important is...", etc.

Recommendation #9: Pay more attention to the manner in which children are addressed in assent forms. In particular, assent forms for adolescents should not refer to "the child".

The adolescent who prompted this recommendation described the problem in the following terms: "I think some other doctor's problem is when they go after the patient's consent, you know, if it's a formality, and not actually something that matters." (L p.5) This was echoed in his parent's recommendation that, as he gets older, "you could probably change it so it's legal but has the child being more of the signer. Make it seem like he is the more important piece because he is." (M p.10)

Recommendation #10: Be careful in the consent documents to distinguish between issues that relate to the protection of research subjects and those that are intended to protect the institution from liability.

Though this issue was most often discussed by the researchers, some parents were keenly aware that consent forms are "...designed more to ward off litigations, they are not designed to protect people... I am not [sure] that is always clear to people when they are signing this form. They think of it only in terms of permission." Another parent puzzled about how to communicate that to people, and suggested that

“it has to be dealt with straightforwardly”. She went on to recommend that, rather than communicating a sense of liability, a more “humane” way of discussing what is at stake for the researchers and families might be to “break it into terms of what the risks are, what they aren’t, what the chances, what the probabilities are, because this is a probabilistic endeavor and it needs to be expressed as probabilistic endeavor.” (C p.4)

Recommendation #11: Be attentive to a larger discussion of risk/benefit.

Several parents talked of being “suspicious” of any narrow definition of cost/benefit analysis as it risked becoming polarized. (C p.4) They emphasized the importance of researchers discussing issues of uncertainty (see page 29) and the relevance of the larger social context. This has important implications for the IRB: how can its regulatory deliberations become more responsive to larger social issues and to the lived experience of patient/subjects and families.

Recommendation #12: Add members to the IRB who have expertise in social and cultural issues and research done in those areas.

Issues and Concerns

Time

Informed consent for research in acute contexts such as the ER is a complex process. The stakes may be very high as patient, family and researcher operate under conditions of high stress. From our vantage point within the everyday practice of informed consent, the subjects all agreed on the importance of time—and that timing can be a barrier or challenge to the process of informed decision making. They spoke of the importance of having enough time to reflect; time for preparation and the need for orientation. Though families and researchers agreed that information is also essential, informed consent in acute situations demands a level of engagement beyond mere information transfer, or the uni-directional disclosure by experts of risks and benefits.

Concern #1: Given the level of stress reported in acute contexts, the IRB and researchers need to give careful consideration to recruiting for studies in the ER, and only do so if it is absolutely necessary.

Interlocutors/Liaison persons. Several families spoke of the benefit of having an ‘interlocutor’ or ‘liaison’. Subjects and researchers alike emphasize the importance of relationship, particularly in high risk situations, which one parent captured in the following words:

Can there be a liaison who can help you work through these questions possibly. But then, there is a part of me that would say, “Well, are they still working as a team? They are all working for Children’s Hospital.” So I don’t know that: a social worker from Children’s hospital would carry different weight or perceived openness or the doctor would. Do you know what I am getting at? Whether they would be able to be independent. Would you still have a feeling that they are a part of Children’s hospital team that is trying to get these studies done? Are they independent enough, we are talking about the perception, would they be independent enough to help you walk away from it if that felt like the right thing to do? (D p.7)

Concern #2: Especially in acute situations, it is important for families to have enough time to reflect, time for preparation, and need for orientation. It is essential to consider carefully who, how, when, and if families would choose to involve others (including any liaison) in a dialogue about informed consent.

We feel that is crucial to determine beforehand, when involving others in the informed consent dialogue, whom such a liaison should be; when and how they would be called upon; and under whose auspices. Would they be given a formal title such as “consent monitor” or “ombudsman”? Would their function be viewed as that of surveillance, or evaluation, or support? In emphasizing relationship rather than a regulatory approach, our subjects and researchers felt the possibility of bringing in a “third party” to be important, and that it should be tailored to the particulars of each situation. We agree: it is most important that the family is given the opportunity to participate in any decision to bring in a “liaison”, and in who that person might be, and that it be offered as an *option* that arises in response to a particular family, rather than as an externally imposed requirement.

This need for a “witness” is also mentioned in recent literature: “preferabl[y] one trusted by the patient’s family (relative, pastor, neighbor, etc.)” [Anand, 2004], but he cautions that “to put these recommendations in another set of regulations would not be welcomed.” How to address these concerns opens up another set of non-trivial conundra.

This is echoed in Jay Katz’ (1993) concern about the vulnerability of subjects considering participation in human experimentation—unless we can develop the capacity to enter into a particular kind of “conversation” or “dialogue” in which time is invested, “...self-determination can become compromised by condemning physicians and patients to the isolation of solitary decision making, which can only con-

tribute to abandoning patients prematurely to an ill-considered fate” (Katz, 1993, p.36).

Both in acute and in high-risk cases, families talked of the importance of having sufficient time in which to deliberate, and of having an “interlocutor”, a “partner” to reflect on what is at stake for them to make a more fully informed decision. One adolescent suggested that this could be another member of the research team, “...who comes in and tells you everything... acts as a safety net, ... from a doctor who just couldn’t be bothered by a dumb kid asking a lot of questions”. (Q p.10)

Uncertainty

A sense of uncertainty is not a trivial matter and both parent and child can carry it with them long after a decision is made to participate (or not) in research. Even after coming to feel that they’ve made the right decision with what was at hand, there may still be nagging concerns.

Concern #3: Discussion of uncertainty needs to be incorporated into the consent process; researchers need to be attentive to these concerns at all stages of the research.

From isolation to community

Everybody that comes in that door, I try to talk to them because I know how I felt the first week I came, and how numb I was and I know what it’s like to have that look on your face like you’re lost. And I see that everyday. Everyday somebody comes in with that look. (A p.5)

In the course of our meetings, families and researchers talked about their concerns and dilemmas arising from their recruitment in the ER. In elaborating on these problems, they made visible new ways in which they could be addressed, as well as suggesting new possibilities for practice. The subjects and their parents often spoke eloquently of the isolation they have faced in navigating the shock of an acute illness, or in living with a chronic illness. It is remarkable to find that, while each subject is recruited individually and treated statistically as if they are separate, in the context with their particular illnesses, they come to know that they are part of a community of families. They speak of a yearning to be “in community” as one way to gain the kind of understanding that comes with this orientation, not just the factual information concerning their illness. From the desire to “see a child who has made it to 4 years old or 7 years old who has the “illness of my 3 month old,” (F p.9) to the teenager who wants to learn from her participation in research “...the different opinions from different people about how they react from [my] condition,” (O p.5) they evidence a strong desire

to participate in the community of patients, of participants in research. Particularly in the culture of Children’s Hospital, there is a continuity of relationship that forms the background to participation in research. They report that it is most critical in research with high stakes chronic illness to have ongoing dialogue and accessibility to researchers. (See the “Results” and “Discussion” sections.)

Members of several departments in our study (see the “Results” section on page 9) talked of efforts they have made clinically to link together people with the same illness, or who have had the same procedure, as one way to build community among patients who otherwise might have remained isolated. This is always presented *as an option* that has been very appreciated by the patients.

Concern #4: The unofficial and informal nature of this kind of connection should be respected and acknowledged. It should be offered as an option, tailored to the specific circumstances.

In addition to face to face contact, some concrete recommendations for a “virtual” connection might include that the hospital should “...provide things like going on line,” (C p.2) or create a virtual “chat room” for children who are in the hospital for long periods of time. (G p.1)

Final recommendations

For researchers

Appointments for consent: Subjects and families emphasize the importance of time to properly reflect on participation in any study, particularly high-risk and chronic illness. This would be a way of giving “prior warning” and “making sure that the doctor doesn’t just walk in to his patient and at the beginning of the appointment and say, ‘Here, sign this’”. (Q p.9)

Recommendation #13: Thought should be given to scheduling appointments solely for the discussion of a clinical trial.

Involve children: Throughout our report we have emphasized the importance of including the voices of children. More than one parent reminds us that, at least initially, “the Dr. is a stranger”. One way to be attentive to this is to remember ‘beginnings’ and introductions.

Recommendation #14: “Manners are important,” especially when approaching children and young adults.

In moving from encounters with strangers to the kind of involvement necessary to make important decisions, this

teenager talks about what is felt as rudeness and that, “manners” are important. Her advice:

Listen. Know what you are doing before you go in and know your audience. And introduce yourself. Don’t just say your name but where you are from and why you are there. Because when you are in the hospital room, you get so many people coming in and out and you don’t know who they are half the time. Then they start asking you questions and I need to know where you are from first. (I p.8)

Families recommendations for families

In this final section we return to the purpose of the project, to hear the ‘voice’ of the families themselves, now advising other families about informed consent. We reiterate below the core concerns as reminders of what has been further elaborated in the Results and Discussion sections:

Recommendation #15a: *Take time*—woven throughout this report is the notion of Informed Consent as a step-by-step process, “...talking about it over a period of time, not saying, This is it. I need a decision.” (P p.10)

Recommendation #15b: *Participate actively*—families advise parents to: “Ask questions and make sure you understand everything.” (I p.12)

Recommendation #15c: *Empower the child*—a reminder to parents and researchers to include children in decision making: “... whether it’s the parents or the doctors, I don’t know. Because it is their body, they need to be a part of the decision making process.” (M p.11)

Recommendation #15d: *Be on the same team*—children advise parents that “when you are with doctors, just be on the same team”, “Just make sure you understand where it is coming from; you let your kid know that you are on his side. Because I think there are definitely teams here, you know what I mean. When you are with doctors just be on the same team.” (L p. 8)

Recommendation #16: Continue the conversation between the multiple stakeholders: families, researchers and the IRB, both formally and informally, that was begun in this study.

A concluding comment

The key shift in the initial stages of this ethnography was when AK started to be seen, not as a ‘policeman’ or instrument of surveillance, but as someone interested in learning *from* and *with* participants about what was at stake for each of them in informed consent as a “local moral world” (Kleinman, 1995). This shift produced an atmosphere in which all the subsequent findings were expressed. In other words, the ethnography was conducted in the same spirit as that which we are now recommending for the conduct of the informed consent process itself.

We shall remember the words of the participants in this study as signposts for further exploration of the world of those who are asked to participate in research and those who ask them. Time and again, these various stakeholders emphasized that there is no “one size fits all” to informed consent. It is a developmental process in which a series of vitally important judgments should be made *with* the patient/subjects and their families, never just *for* them.

ACKNOWLEDGEMENTS

The work was funded by the NIH under NIH grant SO7 RR01850-01 (PI James Mandell) to Children's Hospital Boston, under a subcontract to Harvard Medical School.

We should like to express our thanks to our consultants, Elliot Mishler and Michael Fischer, for their support and wisdom at all stages of this research. Thanks also to our “interlocutors”, Allan Brandt, Mario Biagioli, and Byron Good, for numerous conversations that helped to shape the work.

Our thanks also go to Robin Pierce for her contributions to the early stages of this project, and to our research assistant and transcriber of audio-tapes, Alla Zaytseva, for her interest in the patient-doctor relationship.

We'd like to repeat our thanks, expressed in the Preface, to the Co-chairs of the Children's Hospital IRB, Peter Wolff and Susan Kornetsky, who have facilitated this study as a contribution to their interest in discovering what goes on in the practice of informed consent.

And we would especially like to thank the participants—children, adolescents, parents and researchers—for teaching us what matters most in informed consent.

This report is dedicated to Jay Katz for his inspiration and commitment to that central issue of informed consent—the “Silent World” of all who participate in medical research.

REFERENCES

- Allmark, P., Mason, S. (2003) Obtaining Consent for Neonatal Research, *BMJ*, Vol. 88:3.
- Anand, S. e-mail response to LIT-UP 04-30R.
- Barbour, R. S. (2001) Checklists for improving the rigor in qualitative research: a case of the tail wagging the dog? *BMJ*, 322(7294), pp.1115–1117.
- Broome, M., Richards, D., Hall, J. (2001) Children in Research: The Experience of Ill Children and Adolescents, *Journal of Family Nursing*, Vol. 7:1.
- Fisher, C. (1997) A relational Perspective on Ethics-in-Science. Decision-making for Research with Vulnerable Populations. IRB: A Review of Human Subjects Research, The Hastings Center, Vol. 19:5.
- Fisher, C. (1999) “Relational ethics and research with vulnerable populations”, in Research involving persons with mental disorders that may affect decision-making capacity, Vol II, Commissioned papers by the National Bioethics Advisory Commission, pp.29–49.
- Fontana, A., Frey, J. H. (2000) “The interview: From structured questions to negotiated text,” in Denzin, NK and Lincoln UX, (eds), *Handbook of Qualitative Research*, Thousand Oaks: Sage Publications, pp.645–672.
- Giacomini, M. K., Cook, D. J. (2000) User’s guides to the medical literature: XXIII. Qualitative Research in health care—are the results of the study valid? *JAMA*, 284(3), pp.357–362.
- Katz, A. M. and Mishler, E. (2003) Close Encounters: Exemplars of Process-Oriented Qualitative Research in Health Care, *Qualitative Research*, 3(1), pp.35–56.
- Katz, A.M., Conant, L., Inui, T., Baron, D. and Bor, D. (2000) A Council of Elders: Creating a Multi-Voiced Dialogue in a Community of Care, *Social Science and Medicine*, Vol. 50(6), pp.851–860.
- Katz, A. M. and Shotter, J. (1996) Hearing the patient’s voice: toward a ‘social poetics’ in diagnostic interviews, *Social Science and Medicine* 43:919–931.
- Katz, J. (1980) Disclosure and Consent: In Search of Their Roots. Genetics and the Law II, Eds. Aubrey Milunsky and George J. Annas. NY: Plenum Press, pp.121–129.
- Katz, J. (1984) *The Silent World of Doctor and Patient* (NY: The Free Press, pp.112–113.
- Katz, J. (1993) “Ethics and Clinical Research” Revisited: A Tribute to Henry K. Beecher. Hastings Center Report, 23, No. 5, pp.31–39.
- Katz, J. (1998) Reflections on Informed Consent: 40 Years after its Birth. *J. American College of Surgeons*, 186, No. 4, pp.466–474.
- Kleinman, A., (1995) *Writing at the Margin: Discourse Between Anthropology and Medicine*, Berkeley: U. Cal. Press.
- Knafl, K. (2001) Informed Consent Reconsidered: Family Members’ Perspectives on Participation in Clinical Trials, *Journal of Family Nursing*, Vol. 7:1.
- Kodish, J. (2003) Informed Consent for Pediatric Research: Is it really Possible? *Journal of Pediatrics*, Vol. 142:2.
- Malterud, K. (2001), Qualitative research: standards, challenges and guidelines. *Lancet*, 358, pp.483–488.
- Mason, S., Allmark, P. (2000) Obtaining Informed Consent to Neonatal Randomised Controlled trials: Interviews with Parents and Clinicians in the Euricon Study, *Lancet*, Vol. 356:2045.
- Mays, N., Pope, C. (2000) Qualitative research in health care. Assessing quality in qualitative research. *BMJ*, 320, pp.50–52.
- Mishler, E. G. (1990) “Validation in Inquiry-guided Research: The rôle of Exemplars in Narrative Studies”. *Harvard Educational Review*, 60: pp.415–442.
- Mishler, E. G. (1996) “Missing Persons: Recovering Developmental Stories/Histories”, in R. Jessor, A. Colby and R. A. Shweder (eds), *Ethnography and Human Development: Context and Meaning in Social Inquiry*, pp. 73–99, Chicago University Press, Chicago, IL.
- Nelson, R., Merz, J. (2002) Voluntariness of Consent for Research: An Empirical and Conceptual Review, *Medical Care*, Vol. 40:9.
- Nelson, R., Reynolds, W., Child (2003) Assent and Parental Permission: A Comment on Tait’s “Do They Understand”, *Anesthesiology*, Vol. 98:3.
- Olechnowicz, J., Eder, M., Simon, C., Zyzanski, S., Kodish, E. (2002) Assent Observed: Children’s Involvement in Leukemia Treatment and Research Discussions, *Pediatrics*, Vol. 109:5.
- Pletsch, P., Stevens, P. (2001) Children in Research: Informed Consent and Critical Factors Affecting Mothers, *Journal of Family Nursing*, Vol. 7:1.
- Robson, C. (1993) *Real World Research: A resource for social scientists and practitioner-researchers*, Cambridge, Blackwell.

- Stenson, B. J., Becher, J.-C., McIntosh, N. (2004) "Neonatal research: the parental perspective", *Arch Disease in Child Fetal and Neonatal Edition*;89:F321–323
- Stevens, P., Pletsch, P. (2001) Ethical Issues of Informed Consent: Mothers' Experiences Enrolling Their Children in Bone Marrow Transplantation Research, *Journal of Family Nursing*, Vol. 7:1.
- Sugarman, J. (2003) Missing the Informed in Consent, *Anesthesia & Analgesia*, Vol. 96:2.
- Titus, S., Keane, M. (1996) Do You Understand? An Ethical Assessment of Researchers' Description of the Consenting Process, *Journal of Clinical Ethics*, Vol. 7:1.
- Warlow, C. (2004) Clinical Research under the cosh again (Editorial), *BMJ*, Vol. 329, pp.277–289
- Young, B., Dixon-Woods, M., Windridge, K., Heney, D. (2003) Managing Communication with Young People Who Have a Potentially Life Threatening Chronic Illness: Qualitative Study of Patients and Parents, *BMJ*, Vol. 326.

AUTHOR INDEX

- Allmark and Mason, 2003 . . . 4
Anand, 2004 . . . 28
Barbour, 2001 . . . 5
Broome *et al.*, 2001 . . . 3
Fisher
 1997 . . . 4
 1999 . . . 5
Fisher, 1999 . . . 4
Fontana and Frey, 2000 . . . 5
Giacomini and Cook, 2000 . . . 6
Katz, A.
 and Mishler, 2003 . . . 5, 6
 and Shotter, 1996 . . . 24
 et al., 2000 . . . 5, 26
Katz, J.
 1980, 1984, 1998 . . . 24
 1993 . . . 28, 29
Kleinman, 1995 . . . 5, 30
Knafl, 2001 . . . 3
Kodish, 2003 . . . 3, 4
Malterud, 2001 . . . 6
Mason and Allmark, 2000 . . . 3
Mays and Pope, 2000 . . . 6
Mishler
 1990 . . . 6
 1996 . . . 5
Nelson
 and Merz, 2002 . . . 4
 et al., 2003 . . . 3, 4
Olechnowicz *et al.*, 2002 . . . 3, 4
Pletsch *et al.*, 2001 . . . 4
Robson, 1993 . . . 5
Stenson *et al.*, 2004 . . . 23
Stevens and Pletsch, 2001 . . . 3, 4
Sugarman, 2003 . . . 3, 4
Titus and Keane, 1996 . . . 4
Warlow, 2004 . . . 22
Young *et al.*, 2003 . . . 4

SUBJECT INDEX

A

Adolescents . . . 27, 29, 30
Agency . . . 21, 22, 24
Altruism . . . 11–12, 14, 21
Anthropology . . . 1, 5, 21
Assent . . . 4, 6
Authority . . . 10, 24

B

Background of study . . . 3–4

C

Case-centered approach . . . 5
Children . . . 3, 4, 5, 6, 11, 14, 17, 22, 24, 27, 29
Clinical investigators . . . v
Coercion . . . 4
Collaboration . . . v, 25–26
Committee on Clinical Investigation (CCI) . . . 5, 26
Communication
 aims . . . 11
 importance for subjects . . . 17
 in informed consent . . . 10–11
 mechanics of presentation . . . 11
 non-verbal . . . 11
Community . . . v, 29
 creating a sense of . . . 16
 sites . . . 6
Competence
 in obtaining informed consent . . . 23
Concerns
 discussion of uncertainty . . . 29
 need for sufficient time . . . 28
 recruitment in ER . . . 28
 respect informal connections . . . 29
Confidentiality . . . 6
Consensus . . . 3
Consent, *see* Informed consent
Cultures . . . 5, 25
 of policy makers . . . 21
 of research institutions . . . 13–14, 21
 of research subjects . . . 21

D

Data analysis and sources . . . v, 6, 9
Decision-making . . . 3, 4
 availability of researchers . . . 15

 process . . . 3, 18

Development

 cognitive . . . 3
 emotional . . . 3
Dialogue . . . 3, 25, 28
Discussion . . . 21–24
Dissent . . . 4, 24
Diversity . . . 4

E

Emergency room (ER) . . . 27, 28, 29
Emotional stress . . . 4
Empowerment . . . 10, 30
Engagement of the child . . . 18
Equipose . . . 3
Ethics committees . . . 9
Ethnography . . . v, 1, 3, 5, 9, 21, 22, 30
Everyday practices . . . 1
Experience . . . v, 3, 4, 5, 15–16, 23
Exploratory phase . . . 5

F

Families . . . v
 advice to others . . . 6
 altruism . . . 12
 as natural resources . . . 26
 benefits of audio-taping . . . 26
 community . . . 29
 consent documents . . . 19
 decision-making . . . 3
 diversity . . . 4
 dynamics . . . 10
 emotional stress . . . 4
 engagement . . . 18
 experiences . . . 25
 first language not English . . . 26
 high-stress situations . . . 28
 informed consent interviews . . . 6
 insight into medical culture . . . 22
 issues with researchers and the IRB . . . 27
 motivation . . . 6, 11
 narratives . . . 5
 recall of informed consent . . . 6
 recommendations for other families . . . 30
 social networks . . . 17
 structure and perspective . . . 3, 18

timing . . . 17
 understanding . . . 3
 Family position . . . 4
 Fast trajectory . . . 4
 FDA approval . . . 13, 15
 Federal regulations . . . 1, 3
 Feeling marginalized . . . 4
 Fieldwork . . . 1, 5, 6, 9, 25

H

Harvard Medical School (HMS) . . . 1, 9, 31
 Health Insurance Portability and
 Accountability Act (HIPAA) . . . 12, 19, 22
 Human engineering . . . 19
 Human experimentation . . . 28

I

Illness

acute . . . 4, 29
 chronic . . . 4, 29
 experience . . . 15
 narrative . . . 15
 threat to life . . . 4

Informants . . . 1

Informed consent

administrative challenges . . . 19
 altruism . . . 11
 as a thing and a set of actions . . . 22
 as engaged involvement . . . 25
 as local moral world . . . 30
 balance of authority . . . 24
 communication . . . 10–11, 17
 competence in obtaining . . . 23
 dialogue . . . 24
 documents . . . 3, 4, 5, 19, 27
 encouraging innovation . . . 26
 engagement . . . 18
 experiences . . . 15–16
 honesty . . . 10
 ideal . . . 25
 implications for children . . . 22
 in high-stress situations . . . 28
 including the child . . . 24
 informal contacts . . . 26
 input-output model . . . 25
 interlocutors . . . 15, 28
 its nature . . . 19
 learning through participation . . . 15
 mechanics of presentation . . . 11
 motivation . . . 11–13, 14–19
 multiple meanings . . . 21

need for more research . . . 3
 need for plain language . . . 19
 objection to “spin” . . . 10
 objectives . . . 3
 obtaining . . . 9
 of parents . . . v, 3
 official discourse . . . 9, 23
 opportunity for empowerment . . . 10
 over time . . . 5
 pivotal moments . . . 10, 24
 politics . . . 18
 preparation . . . 26, 28
 privileged meanings . . . 19
 process . . . 3, 4, 5, 9, 17–18
 regulatory discourse . . . 11
 relational, experiential, performative . . . 21
 relationship . . . 1, 9–10, 19, 25
 risk/benefit assessment . . . 12
 social context . . . 10, 15, 23
 timing . . . 4, 17
 uncertainty . . . 29
 understanding . . . 3, 5, 17, 22
 valued qualities . . . 17
 voluntary nature . . . 17

Institutional Review Board (IRB) . . . v, 3, 5, 6

cultures . . . 21
 encouraging innovation . . . 26
 interviews with members . . . 19–20
 meetings . . . 5, 9
 protocols . . . 9
 relations with researchers . . . 27
 social issues . . . 28
 understanding . . . 22

Interdisciplinary research team . . . 6

Interlocutors . . . 15, 28, 29

Interviews . . . 5, 6

ethnographic . . . 5
 format . . . 5
 group settings . . . 9
 informed consent . . . 9
 methods . . . 1, 5–6
 quantity . . . 9
 style . . . 5
 transcripts . . . 6, 9
 with IRB members . . . 19–20

Introduction . . . 1

Isolation . . . 29

Iterative modification . . . 6

K

Katz, J. . . . 24, 31

L

Learning from challenging subjects . . . 24
 Listening critically . . . 1
 Literature review . . . 3, 4, 5
 Local moral world . . . 30

M

Major findings of the study . . . 25
 Mandell, J. . . . 31
 Medical ethics . . . 9
 Methods . . . 5–6
 anthropological . . . 1
 Misinterpretations . . . 3
 Moral dilemmas . . . 25
 Multiple viewpoints . . . 3, 5
 Mutual inquiry . . . 5

N

Narcissism . . . 13
 Narrative . . . 5, 6, 15
 National Institutes of Health, *see* NIH
 National meetings . . . 5, 9
 New York Times . . . 21
 Newspaper clippings . . . 9
 NIH grant . . . 3, 31

O

Office for Human Research Protection (OHRP) . . . v

P

Parents
 behavior . . . 4
 permission . . . 4
 see also Families
 Participant observation . . . 5
 Participation in research
 circumstances . . . 6
 motivation . . . 6
 Patients, *see* Research subjects
 Pivotal moments . . . 10, 24, 24
 Policy makers themes . . . 19–20
 Politics, *see* Research, politics
 Power asymmetry . . . 4
 Power asymmetry, *see* Authority
 Preface . . . v
 Principal investigator (PI) . . . v, 5, 6, 24, 26
 Processual . . . 21
 Protection of subjects . . . 1, 3, 25
 Purposive sampling . . . 5

Q

Qualitative research
 approach . . . 3
 background . . . 5
 data . . . 6
 ethnographic methods . . . 5
 Quality of life . . . 15

R

Racial identities . . . 10
 Rationality . . . 4
 Recall . . . v
 and remembering . . . 23–24
 from written document . . . 23
 short-term . . . 3
 Recommendations . . . 25–30
 add members to IRB . . . 28
 be on the same team . . . 30
 continue the conversation . . . 25, 30
 creating atmosphere of respect . . . 27
 development program . . . 27
 distinguish care from liability . . . 27
 empower the child . . . 30
 enlarge risk/benefit discussion . . . 28
 informed consent appointments . . . 29
 less technical writing . . . 27
 manner of address . . . 27
 manners are important . . . 29
 participate actively . . . 30
 promote flexibility . . . 26
 reward innovation . . . 26
 take time . . . 30
 Recruitment . . . 3, 6
 References . . . 33–34
 Reflection . . . v, 1, 11, 18, 24, 25, 28, 29
 Regulatory issues . . . v, 5, 19
 Remembering . . . v, 22, 24
 and recall . . . 23–24
 Research
 cultures . . . v
 decision to participate in . . . 5
 design . . . 5–6
 motivation to participate . . . 13
 nurses and coordinators . . . v
 politics . . . 18–19
 protection of subjects . . . 21
 protocols . . . 3
 weekly team conferences . . . 9
 Research institutions
 culture of . . . 13–14, 21

- liability . . . 19, 27
- narcissism . . . 13
- official discourse . . . 21
- politics . . . 18
- Research subjects
 - access to researchers . . . 23
 - alienation . . . 18
 - awareness of vulnerability . . . 9
 - communication . . . 11, 17, 24
 - community . . . 16, 17, 29
 - conversations with . . . 5
 - decision-making . . . 15
 - empowerment . . . 10
 - engagement . . . 18
 - equipoise with researchers . . . 3
 - everyday practices . . . 21
 - experience of informed consent . . . 15
 - federal regulations for protection of . . . 1, 3
 - hearing their voices . . . 1, 18
 - high-stress situations . . . 28
 - identification . . . 1
 - illness experience . . . 15
 - information flow . . . 15
 - level of sophistication . . . 23
 - literature review . . . 3
 - motivation . . . 14
 - pivotal moments . . . 10
 - politics of research . . . 18
 - quality of life . . . 15
 - recall a written document . . . 6, 23
 - recruitment . . . v, 1, 6
 - relationship . . . 10, 28
 - remembering . . . 23
 - risk/benefit assessment . . . 12
 - sources of data . . . 9
 - study sample . . . 6
 - thematic summary . . . 14
 - time and timing . . . 17, 23
 - understanding . . . v, 11, 17, 22
 - valued qualities . . . 17
 - what is at stake for them ? . . . 24
- Researchers
 - active participation . . . 21
 - attitude . . . 19
 - availability during decision making . . . 15
 - bureaucratic obligations . . . 21
 - contacts with CCI . . . 26
 - cultures . . . 21
 - everyday practices . . . 21
 - experiences . . . 25
 - high-stress situations . . . 28
 - issues of uncertainty . . . 28
 - issues with families . . . 27
 - joint meetings . . . 26
 - judgment calls . . . 25
 - manner of addressing children . . . 27, 29
 - pivotal moment . . . 24
 - relationship . . . 10, 15, 19, 27, 28
 - sensitivity . . . 10
 - themes . . . 9–14
 - training sessions . . . 9
 - understanding . . . 22
- Respect . . . v
- Responsiveness . . . 25
- Results . . . 9, 9–20
- Risks and benefits . . . 14, 15, 22, 28
 - assessment . . . 12
 - risk factor . . . 4
 - risk/benefit ratio . . . v
- S**
- Sales pitches, deprecated . . . 17
- Self-doubt . . . 3, 4
- Sequencing of questions . . . 5
- Significant themes . . . 3–4, 6
- Social issues . . . 1, 10, 15, 17, 19, 21, 23, 24, 25, 27, 28
- Stakeholders . . . v, 1, 5, 19, 24, 25, 30
 - changed by pivotal moments . . . 10
 - interests . . . 10, 21
- Subjects, *see* Research subjects
- Surveillance . . . v, 5, 28, 30
- T**
- Themes . . . 6
 - administrative challenges . . . 19
 - communication . . . 10–11
 - experiences of informed consent . . . 15–16
 - for researchers . . . 9–14
 - for subjects . . . 14–19
 - informed consent as a “relationship” . . . 9–10
 - institutional culture . . . 13–14
 - motivation . . . 11–13, 14–15
 - nature of informed consent . . . 19
 - policy makers . . . 19–20
 - research politics . . . 18–19, 19–20
 - structure of the informed consent process . . . 17–18
- Therapeutic benefit . . . 4
- Time and timing . . . 4, 28–29
 - barrier to informed consent . . . 28
 - diagnosis . . . 4
 - importance for subjects . . . 17, 29
 - in acute settings . . . 25

time pressure . . . 4
 Transcripts . . . v, 6, 9, 14
 Triangulation . . . 6
 Trust . . . 9, 15, 23, 25, 26, 27, 28

U

Uncertainty . . . 29
 Understanding . . . 3, 11, 22–23
 evolves over time . . . 22
 implications for children . . . 22
 importance of . . . 17–18

two-way . . . 23

V

Virtual connection . . . 29
 Virtual network of researchers . . . 5
 Voluntariness . . . 4, 10, 17
 Vulnerability . . . 9, 10

W

Witnesses . . . 28

