Jill Harrison:

Hi, this is Jill Harrison, Executive Director of the National Institute on Aging IMPACT Collaboratory at Brown University. Welcome to the IMPACT Collaboratory Grand Rounds podcast. We're here to give you some extra time with our speakers and ask them the interesting questions that you want to hear most. If you haven't already, we hope you'll watch the full Grand Rounds webinar recording to learn more. All of the companion Grand Rounds content can be found at impactcollaboratory.org. Thanks for joining.

Vince Mor:

Good morning or afternoon, whichever the case may be. This is Vince Mor. I'm one of the multi-principal investigators of the IMPACT Collaboratory funded by the National Institute on Aging. And this is a podcast follow up to our monthly Grand Rounds. And today we have the pleasure of having heard Charles Weijer, who's a professor at Western University in Ontario, and an expert in the ethics of doing large scale trials, and he was one of the participants in the Ontario Convention governing the ethical considerations regarding people's participation in large scale randomized trials. Of particular interest today is his discussion about the specific complications that arise when the study subjects are vulnerable. And he's been working on this with his colleagues and thinking about it greatly, and that's what the focus of his Grand Rounds was. And so Charles, thank you very much for being here with us today. Could you just summarize briefly the notions and the main points of your Grand Rounds?

Charles Weijer:

During the Grand Rounds we presented a paper that is forthcoming in JAGS, written with co-authors, Hayden Nix, Emily Largent, Monica Taljaard, Susan Mitchell, and myself, in which we explore issues of vulnerability in cluster randomized trials involving people with dementia in nursing homes. Why this topic? We're of the belief that research is going to be an essential component to improving the quality of care and quality of life of people living with dementia in nursing homes. Interestingly, in this setting, the majority of trials conducted, randomized trials, are actually cluster randomized trials. So almost two thirds of trials in this setting are cluster randomized, and the most comprehensive international guidelines governing that, The Ottawa Statement on the Ethical Design and Conduct of Cluster Randomized Trials, are just now in the process of being updated. So our work aims to contribute to that Ottawa Statement update with a focus on the issue of vulnerability.

Why vulnerability? Well, to be plain, this is such an important issue for people living with dementia and for residents of nursing homes. And when you combine those two you get intersectional vulnerabilities. And that was really the interest that was driving us. We reviewed a sample of 24 cluster trials conducted involving people with dementia in nursing homes, and we reviewed them for reported vulnerabilities, for vulnerabilities that we could identify and protections. We ended up identifying six vulnerabilities, and said something about how a structured approach for protections might be put into place. Briefly those vulnerabilities were inadequate comprehension, inadequate voluntariness, invasions of privacy, undue risks associated with the study intervention, undue risks associated with data collection procedures, and justice concerns about how non-participants in trials might be burdened by the conduct of a trial. So we lay out a framework with potential protections. Our point here is not to say that every protection is appropriate for every trial, but rather to inform a structured discussion that researchers might have with IRBs about each of these vulnerabilities, and to have a discussion about what level of protection is appropriate in each trial.
Great. Thank you so very much. Could you just expand a little bit on what vulnerability is? I mean, I think we understand some sense, in a global sense, of people living in nursing homes, they're kind of constrained, they're institutionalized, they tend to have a higher probability of having dementia, their decision-making capacity, at least we infer that their decision-making capacity might be impaired. So you made a statement in the Grand Rounds, which I thought was really interesting. You said you're focused on additional or greater wrongs or harms as a result of research participation. Could you sort of clarify what you mean as a result of research participation in the context of the different kinds of cluster randomized trials that you reviewed?

Charles Weijer:

Great question. I mean, of course we talk about vulnerability in sort of a folk or common sense kind of way. We all have a sense of what we mean by that. We're all vulnerable in some sense. And as you've nicely explained, there's a sense that people living within nursing homes have perhaps certain vulnerabilities. But in research ethics, there's actually a very specific meaning associated with vulnerability. The vulnerable are those in research who require additional protections. And the way I think about this is to say, look, we have ethical duties. Researchers have ethical duties to research participants generally, duties of respect for persons, beneficence, and justice. And those get operationalized in sort of typical ways. There are fairly standard procedures around informed consent, around thinking through harms and benefits in trials, and thinking through what constitutes fair participant selection for participation. And those are sort of the ordinary protections that you'll find in any randomized control trial.

What's different about vulnerable people, for instance, someone who lacks decision making capacity or someone who has intermittent decision making capacity, is that the existing protections aren't enough for that person. So when we think about vulnerability, it's individuals who are at a greater risk of being wronged as a result of research participation. It's a flag for us to of think in order to, for instance, fulfill our duty of respect for persons what else do we need to do to ensure that someone who's lacking capacity, or who has intermittent decision making capacity, to ensure that they're not wronged as a result of research participation? So that's kind of how we are thinking about vulnerability and protections in this study.

Vince Mor:

Great. So one of the questions was actually focused on this concept of intermittent vulnerability or intermittent cognitive impairment in early stages of dementia or with people who have psychosis or periodic delirious events related to medication or otherwise. How does a researcher grapple with this issue of intermittent acceptability or excess vulnerability?

Charles Weijer:

Right. That's such a great question and I think a difficult scenario clinically, I mean this is something that's dealt with in emergency departments, in internal medicine wards every day. The person with marginal or intermittent decision making capacity, how best to deal with that. And it's also a difficult question in the context of trying to do a randomized control trial in the nursing home. I think for me, really the best approach is to recognize that the resident is perhaps having a good day now and perhaps having to have a robust conversation about participating in research. But there's a likelihood as time goes on that there'll be days when they won't be able to do that.

So how to manage it? And I think the key here is to involve the family caregiver and really involve them such that you're really treating the resident and the caregiver as, functionally, a dyad. They're both
included in all conversations about the trial so that the caregiver can hear what the resident wants on
days when they're able to express that. And on days when the resident is not really able to participate in
those discussions as much, you have an informed, involved family caregiver who can speak on their
behalf on those days. And in a sense, functionally it's treating them like a pair. I think that might be a
useful way of going forward in these difficult situations.

Vince Mor:
Thank you. Thank you. So one of the examples you used was based on one of the studies that was
included in your review, was one of the studies that I happen to lead on bathing, study of bathing
without a battle, in which we had external research staff, who happened to be clinicians, who'd been in
the nursing home before, and they observed patients and staff during the course of a bathing episode.
We certainly had consent from all of the patients, actually mostly from the family members, because
these were quite impaired individuals. But we had the observation, and we spent a lot of time thinking
about context under which to observe, not observe. We actually trained our data collectors using videos
that somebody else had done during their earlier trial, the earliest trial of this. You raised the point of
are there some alternatives that might be less-

Charles Weijer:
Yeah, alternatives that might mitigate invasions of privacy.

Vince Mor:
Yeah, the invasion of privacy. You thought about some alternatives to that which were of interest.

Charles Weijer:
Yeah, I mean look, Vince, I think the bath trial is just such a phenomenal study. The training intervention
that you rigorously studied in that trial and demonstrated to be effective at improving the quality of
care bathing patients. And I think it's such an important result. And I think it's also, just to make clear, I
mean I think it was also plain just how much thought you and your colleagues had put into the issue of
privacy in that study. So we're certainly not trying to second guess you and your colleagues, we think
you did a great job. And I think what we're trying to do here is just use that as an example of an
outstanding trial and just sort of say, moving forward, how can other researchers design and conduct
similarly outstanding trials? Our addition here, I mean our contribution is to say, look, it would be really
useful for researchers, and ultimately researchers and IRBs, to have a structured conversation about
how data collection is going to work in settings like bedrooms and bathrooms and nursing homes where
privacy is a prominent issue.

And the way that that conversation is going to go is really just to consider a range of alternatives that
are really ways of minimizing potential invasions of privacy. So some of the questions that we propose,
that researchers sort of think about when doing research in this setting is right. Do you need to have the
researcher present gathering data? Is there an opportunity here to train care home staff while they're
providing care to record some data at the same time? If that isn't possible because care home staff are
very busy, is it possible then to perhaps train researchers to administer some targeted aspect of care
and gather data while they're doing that? And if that isn't possible, is it possible to otherwise limit the
observation of the researcher in that setting, for instance, by just listening to the encounter rather than
observing it and listening. We're not presupposing what the right answer is for any particular trial, but
we just think that's an important conversation to have so that the degree of invasion of privacy is
minimized consistent with the scientific ends of the study.
Vince Mor:
Well, I think that's really important, and not being sort of an ethicist and not having that in the top of my mind it's probably for many researchers, I won't say most, being pushed to go that extra mile or at least consider what the alternatives would be I think is a really good injunction as it were. But it does lead to me sort of my last question, which has both design implications but also emerges directly from something like a Bathing Without a Battle implementation and how to do that, particularly engaging the staff.

So quality improvement programs, and in the US we have a institutionalized structure called QAPI, which is a Quality Assurance Program Implementation. And so that program is now a regulatory requirement in U.S. nursing homes, and so nursing homes have to, let's say we want to overcome the problem of behavioral outbursts during bathing, which is a difficult, intimate time, particularly for people with dementia. So you may want to put that training into place and then monitor that process. So the question is how can you do that under a more rigorous strategy than many QI processes are, which is sort of just highly local, where in some sense you do want to have some dissemination and broader research agenda that emanates from a quality improvement initiative, even though it's only locally focused.

Charles Weijer:
Right. So what I'd like to see, and I'm guessing that you and I are very much on the same page here, is I'd like to see more quality improvement research. I'd like to see promising quality improvement initiatives evaluated using rigorous methods, including randomized control trials across multiple nursing homes, so that we can generate high quality evidence, not just to improve the care at one nursing home, but to improve the care for all residents at all nursing homes. I mean, I think that should be our ultimate goal. There's something a bit funny about how the current system of ethics oversight is sort of unstructured and everything rests on a single distinction between whether something is research involving human participants or it isn't, right? And if you fall into that research involving human participants category then now you're subject to federal regulations, to IRB review, and in a process that's perceived to be, and I suspect correctly, as pretty burdensome.

Whereas if what you're doing isn't research, if it's not a systematic investigation designed to produce generalizable knowledge, if it really is just about improving care just for your local nursing home, none of that applies. My worry is sort of twofold here. One is that surely there are ethical issues when quality improvement initiatives are instituted locally. I mean, they have an impact on residents, and part of the reason we're evaluating them is we don't know whether that impact is going to be good or not. And so I think it's plain that there are ethical issues involved in non-research quality improvement activities, and that's a space where there really hasn't been sort of enough thinking about what those ethical issues are and what reasonable protections would look like for that setting.

So that's some work outside of research ethics that needs to be done. But even more important, I think the way the system is currently structured creates a perverse incentive basically for people evaluating quality improvement initiatives to not apply rigorous methods to avoid the categorization of research. And that strikes me as being deeply problematic because we end up in sort of a hodgepodge one-off basis implementing quality improvement care improvement initiatives from one nursing home to the next without generating a rigorous evidence base to guide the improvement of quality of care across all nursing homes. And that strikes me as actually a pretty serious problem with our current regulatory structure.

Vince Mor:
Thank you. That's a great place to end. That was just a lovely comment and I look forward to hearing about your continued work in this area and expanding the reach, as it were, of this kind of ethical focus on how care gets done. Dr. Weijer, thank you very, very much for your time, both a great Grand Rounds yesterday and this lovely talk in our podcast. Thank you very much and have a great day.

Charles Weijer:
Thanks so much Dr. Mor. It was an absolute pleasure.

Jill Harrison:
Thank you for listening to today's IMPACT Collaboratory Grand Rounds podcast. Please be on the lookout for our next Grand Rounds and podcast next month.