

**Outcomes in  
clinical research  
—whose responsibility?**

**A seminar jointly organised by**

—The James Lind Alliance.

—The Social Science Research Unit, Institute of Education,  
University of London.

—The Royal College of Nursing Research Institute,  
University of Warwick.

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# Introduction

At a seminar entitled ‘Outcomes in clinical research: whose responsibility?’, held on November 20th 2008 at the University of London’s Institute of Education, Sir Iain Chalmers of the James Lind Alliance (JLA) emphasised the importance of the question being posed at the event. Sir Iain noted that little regard has been given to patients’ views about their goals for clinical research. Patients also have a limited say in what outcomes are to be measured in clinical trials.

By way of example, he mentioned that only two of the dozen clinical trials undertaken to assess the effectiveness of epidural analgesia during childbirth asked the women being treated about their experience of pain during labour.

Patients with the same condition may have different preferences among the treatments on offer, added Sir Iain. A patient’s willingness to accept a medical intervention’s risk-benefit trade-off may affect their choice. Selection may be guided more by personal convictions than by clinical rationale—as found, for instance, by a study that analysed the treatment

## **The James Lind Alliance and DUETs**

The James Lind Alliance (JLA), founded in 2004, argues that addressing uncertainties about the effects of treatments should become a routine element of clinical practice, and that patients (and their representatives) should be involved in the selection, design and implementation of clinical research.

As part of this effort, the UK Database of Uncertainties about the Effects of Treatments (UK DUETs), publishes unanswered questions from patients and clinicians, to help identify research priorities.



choices of US men with cancer of the larynx. Some affected patients chose radiotherapy from the two potential treatments. Radiotherapy has the advantage of not destroying the patient's voice. Other patients picked the second treatment—surgical removal of the larynx, which deprives patients of their voices, but offers prospects of slightly longer-term survival.

Sir Iain described two main challenges confronting medical researchers. The first is the need to find ways of helping patients shape the clinical research agenda. The second is the need to develop robust methodologies for collecting 'patient-important outcome measurements' in clinical trials. Thus far, he indicated, efforts on both fronts have been minimal. Hence this ground-breaking seminar, which brought together some 150 academics, clinicians, policymakers, government officials, executives from patient organisations—and patients themselves.

The seminar was divided into two parts. Morning discussions examined the issue of networking and engaging patients in clinical research. In the afternoon, seminar attendees were asked to comment on a variety of JLA-sponsored projects which sought to develop a list of priorities for future medical research in different disease areas, and which sought to communicate with patients and patient groups, as well as clinicians.

The main aims of the day:

- Promote debate about the role of patients, clinicians, and researchers in determining the important outcomes to be measured in clinical research.
- Provide examples of patient-reported outcomes and patient-important outcomes.
- Explore how best to improve the influence of patients and the public in clinical research outcomes.
- And increase networking among patient groups, charities, clinicians, researchers, and other health-research stakeholders.

### James Lind

James Lind was an 18th-century Scottish naval surgeon who showed that citrus fruits were an effective treatment for scurvy—at the time, a major killer of sailors. Lind's celebrated *Treatise of the Scurvy* confronted the uncertainties about the treatment of the disease through rigorous scientific pursuit, based on two methodologies:

- 1.) A systematic review of the relevant empirical research; and
- 2) A controlled trial within routine clinical practice.

The approach, suggested Sir Iain Chalmers, is as valid today as it was then.

# The importance of outcomes, and how they should be measured

Patient and public involvement in the planning and conduct of research has been a longstanding concern of Sandy Oliver, Professor of Public Policy, and Deputy Director of the Social Science Research Institute at the Institute of Education, University of London. Professor Oliver accordingly took on the challenge of offering answers to the question posed by the seminar's title, 'Outcomes in research: whose responsibility?'

## **What are outcomes—and how can they be used?**

Professor Oliver opened her talk by explaining the value of 'outcomes', and their use as a measurement to support decision-making in healthcare. Knowing how treatments and other medical interventions work—in other words, knowing about outcomes—can help patients take personal decisions regarding their own care. Outcomes also enable societies to take collective responsibility when selecting the services that should be made available within healthcare systems—the effectiveness of which are inevitably limited by finite financial resources.

Professor Oliver insisted that research must concentrate on outcomes of treatment that are plausible, important, and measurable. In other words:

- The outcomes have to make sense (and be relevant and practical) to patients, carers, clinicians and researchers, so that these sets of people are able to reach important decisions about whether or not to proceed with treatment or care.
- The outcomes are measurable with the technical know-how, staff, and research resources available (and with the good will of the study participants).

When selecting which outcomes should be measured for a given medical condition and/or treatment, complex issues are at play. In particular, desired and undesired effects of a medical intervention need to be equally considered.

To allow the seminar's discussions to benefit from input by audience and speakers alike, a questionnaire had been circulated before the meeting, inviting participants to suggest important outcomes (desirable or not) related to conditions with which they were familiar. Attendees were also asked to reflect on the challenge of the task of selecting outcomes. After reading the questionnaire's responses, Professor Oliver was able to affirm that the personal perspective of any single individual is limited. No one person can imagine the full panoply of effects that treatments and care may have on populations. And, without knowing results, it is also hard to decide which, out of a possible basket of outcomes, should be prioritised for inclusion in research. Listing a medical condition's clinical symptoms and the desired effects of a treatment may be easy; far harder to select which one is the most important—and therefore worthy of measurement—and to decide why.

Professor Oliver quoted one service user:

"I'm afraid that it is not possible to rank the desired effects in this way. [This condition] is multi-faceted; the facets vary in intensity in any one individual, over time, and between individuals. What matters is to ensure that all the effects of the disease are included in the outcome measures."

But, in spite of the obvious limitations, added Professor Oliver, people have a right (whether an ethical right or a right associated with citizenship) to be involved in decisions about research processes that affect them. Moreover, including a broad range of people in research decision-making

can be justified on pragmatic grounds—to decide not just the key problem areas in need of research, but also how that research should be carried out. Involvement of patients ought to have the net effect of encouraging greater acceptance of the end results among users.

### **Developing research priorities**

Deciding which problems most deserve to be researched demands knowing something about living with conditions, and the implications of treatments, as well as about the purpose of the research. When such knowledge is held by different types of people, then individuals skilled in communicating with them are required. To improve research or research use, understanding the purpose of research is not enough. Also to be comprehended are the nature, potential, limitations, and options for research—factors that need to be discussed by all concerned stakeholders.

A number of roles are vital in the bringing together of the knowledge and skills



essential for choosing outcomes and measures. Researchers design the measures (and, in doing so, listen to networked patients, carers, and health professionals who can speak on behalf of their peers). Individual patients, carers, and health professionals are necessary to pilot the measures. A further prerequisite are facilitators (of whatever background) to help different people be aware of each others' issues, and to work together.

In Professor Oliver's view, research priorities can be reached collectively if the decision-making can be shared across the various categories of people who have a stake in a clinical study. [Editor: Such networking is a cornerstone of the JLA.] Each has a role to play, but no single set possesses all the answers.

Professor Oliver's suggested answer, then, to the question inherent in the seminar's title—'Outcomes in research: whose responsibility?'—was that no one body of people should be held responsible. Instead, a shared effort should embrace all who are interested in the particular medical condition/treatment under examination.

Professor Oliver cited the following references in support of her views:

#### **World Health Organisation**

International Conference on Primary Health Care, Alma-Ata, USSR, 1978.

#### **Philosophy of communication**

The ideology of Jürgen Habermas about fair play in speech, and mutual understanding.

#### **History of public involvement in science**

Collins and Evans, 'The third wave of science studies: studies of expertise and experience', *Social Studies of Science*, 2002, vol 32, no 2, pp 235-296.

#### **Study of expertise**

Stewart, *The Communication of Expertise in the Context of Multi-Disciplined, Participatory, Problem-Based Training in Evidence-Based Decision-Making*, PhD thesis, 2007.

#### **Studies of getting research findings into decisions**

Greenhalgh, et al, 'Diffusion of innovations in service organisations: systematic review and recommendations,' *The Milbank Quarterly*, 2004, 82, 4, pp 581-629.

# About PROMs

Dr Kirstie Haywood, senior research fellow at the School of Health and Social Studies at the University of Warwick, is heading the efforts of the Royal College of Nursing Research Institute (RCNRI) in the area of patient-reported outcomes (PROs). Speaking at the ‘Outcomes in clinical research’ seminar, she re-emphasised Sir Iain’s comments on the importance of developing a repertoire of measures to collect PROs (known collectively as patient-reported outcome measures, or PROMs)—and the difficulties of doing so.

Whatever measures are developed, stated Dr Haywood, their designers need to be certain that ‘real’ patient-reported outcomes are captured—in other words, outcomes of importance to the patient. Furthermore, findings need to be put into the context of patients’ priorities. Although clinicians may argue that they have taken patients’ perspectives into account, what these researchers mean for the most part is that patients have been assessed by some physiological or laboratory-based yardstick, which may be of little relevance to the daily lives of patients.

In principle, activities that aim to place the patient centre-stage in healthcare should have UK government support, since patient and public involvement is supposed to be a central government policy initiative.

## **How the FDA defines patient-reported outcomes (PROs)**

“Any report coming directly from patients, without interpretation by physicians or others, about how they function or feel in relation to a health condition or its therapy.”

<http://www.cochrane.org/podcasts/brasil/powerpoints>



### Three types of patient-reported outcome measures (PROMs)

- (1) **Generic:** all-purpose measure that can be applied to a wide range of studies.
- (2) **Specific:** say, for one condition, or one population.
- (3) **Individualised:** where the important outcomes included in a measure are specifically identified by an individual patient.

Guidance is available to help choose which type of PROM is suitable for inclusion in clinical research (for example, <http://nchod.uhce.ox.ac.uk>). Many reviews of PROMs exist. In January 2006, for instance, the European Medicines Evaluation Agency (EMA) produced a report on the use of PROs and the assessment of health-related quality-of-life issues [<http://www.emea.europa.eu/pdfs/human/ewp/13939104en.pdf>]. In February 2006, the US Food and Drug Administration (FDA) issued its own set of recommendations [<http://www.fda.gov/cder/guidance/5460dft.pdf>]. The multi-disciplinary group OMERACT (Outcomes Measures in Rheumatology, <http://www.omeract.org>) has developed advice on how to measure PROs across a range of rheumatological conditions. Since 2002, patients have been actively involved in the OMERACT process.

So, queried Dr Haywood, what do patients think about when getting medical treatment? She observed that patients usually ask for two major questions to be answered:

- 1.) Will I live longer?
- 2.) Will I feel better?

Both issues might refer to the patient's family and carers as much as to the patient. A further complication is that when patients talk about feeling better, they may be referring to experiencing less tiredness or pain, or more emotional well-being, or even the ability to go back to work. Such outcomes are not necessarily registered by conventional clinical research.

Interest in measuring PROs is growing, reflected Dr Haywood. In 2002, Dr Andrew Garratt and colleagues at the National Centre for Health Outcomes Development, University of Oxford [<http://nchod.uhce.ox.ac.uk>] found evidence that more than 1,200 PRO measures (PROMs) were available [<http://www.bmj.com/cgi/reprint/324/7351/1417.pdf>]. But the group also discovered that not all PROMs were reliable and able to generate valid data. In some cases, measures were first filtered by clinicians—meaning that a doctor's view was imprinted upon the end result, rather than the patient view. To be credible, said Dr Haywood, PROMs need to be applied systematically, in a clearly definable (structured) way—and they must involve the patient directly.

Dr Haywood stressed that when the primary goal of treatment is improvement in how a patient feels, the patient's perspective becomes imperative. "And some outcomes can only be expressed by patients", she commented. The same is true when PROMs are used in clinical trials, she added. If PROs are deployed properly, the patients are more likely to 'buy into' the treatment.

Any clinician aiming to include PROMs in their trials must ensure that the measure concentrates on patient outcomes of relevance to the research, and that the findings are valid, reliable, and responsive to changes important to the patient (such as being less tired, or being in less pain).

### Three case studies

The Internet (especially the YouTube website) and even the media are valuable resources to use to begin trying to understand the feelings and needs of people with specific disease conditions. The Patient Experience Database in ME (PRIME), for example, has benefited from these and other sources when documenting and analysing the patient experience in the subject area of **myalgic encephalopathy/chronic fatigue syndrome (ME/CFS)**.

Information for PRIME has been accumulated through literature searches and interviews with patients. Comments from bed-bound and housebound patients collated by the charity CHROME (Case History Research on ME) have also been amalgamated into PRIME. In 2006, PRIME became a publicly-available, searchable online database [<http://www.prime-cfs.org>].

Dr Haywood and her colleagues at the RCNRI have recently completed the enormous task of reviewing published studies of questionnaires (PROMs) completed by people with ME/CFS. The intention is to compare the results with the outcomes that are typically used to assess ME/CFS in the clinical setting—which may not be outcomes of primary concern to patients. When contrasted against outcomes identified as important by patients with ME/CFS, issues such as fatigue, social well-being, physical disability, and general well-being take priority.

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In June 2008, the *Journal of the American Medical Association (JAMA)* published a review of registered **diabetes** trials undertaken by Dr Gunjan Y. Gandhi and colleagues from the Mayo Clinic, Rochester, Minnesota, and McMaster University, Hamilton, Ontario [<http://jama.ama-assn.org/cgi/content/abstract/299/21/2543>]. The purpose of the review was to determine the extent to which ongoing and future randomised clinical trials in diabetes are (or will be) including what the authors called patient-important outcomes (PIOs).

Of the 436 trials registered since 2004 and reviewed for this study, only 18% included PIOs as primary outcomes. A further 28%, though, reported PIOs as a secondary outcome that they were (or would be) measuring. In most cases, however, the clinical trials were largely run to assess outcomes decided by clinicians.

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Ever since including patients within its multi-disciplinary team, OMERACT has been alert to the need to embrace patient perspectives when deciding which outcomes should be measured in randomised clinical trials of **rheumatoid arthritis (RA)**. Prior to OMERACT's incorporation of patients, RA clinicians typically focused on one or more of eight end-points that mostly related to measures of physical disability. In 2002, a further pair of patient-defined end-points were added—a fatigue and a general well-being index known as HRQL.

### **In conclusion**

Dr Haywood pointed out that many questions still need to be considered if patient-reported outcomes are to become an accepted norm in clinical trials procedure. In particular, constant attention has to be paid to whether clinical trials are measuring the “right thing, the right way”. Also needed are greater standardisation, consensus, and guidance about the optimum ways to deliver PROMs.

Dr Haywood ended with a quotation from the late John Tukey, a US statistician whose words have been repeated at many PROMs-related events:

“It is often much worse to have good measurement of the wrong thing—especially when, as is so often the case, the wrong thing will in fact be used as an indicator of the right thing—than to have poor measurement of the right thing.”

# Patients designing patient questionnaires

Dr Alexandra Wyke of the UK company PatientView spoke to the 'Outcomes in clinical research' seminar about a difficulty that emerges with PROMs—the design of the questionnaires that seek to elicit responses from patients.

In her talk, Dr Alexandra Wyke described a novel approach to the design of patient questionnaires, spearheaded by PatientView with input from a multidisciplinary expert team. The new form of questionnaire design seeks not only to produce questionnaires with questions that are more meaningful to patients, but also to generate results that will enable researchers to determine priorities for different types of patients with greater accuracy, and in a systematic manner.

The alliance of stakeholders that helped PatientView formulate the new type of questionnaire informally call themselves the HAPPI (Health and the Positive Patient Instrument) panel. Several members of the HAPPI panel are linked with the James Lind Alliance (JLA). (Representatives of the National Audit Office [NAO] and the National Institute of Clinical Excellence [NICE] were present as observers at the HAPPI panel meetings.)

## Current members of the HAPPI panel

- Associate Parliamentary Limb-Loss Group.
- Commissioning Health.
- The Heller School for Social Policy and Management, Brandeis University.
- Diabetes UK.
- Developing Patient Partnerships.
- Different Strokes.
- emPOWER Charities Consortium.
- Incontact (Action on Incontinence).
- Juvenile Diabetes Research Foundation.
- Limbless Association.
- MacMillan Cancer Support.
- Patient Information Forum.
- PatientView.
- Royal College of Nursing Research Institute.
- Roy Castle Lung Cancer Foundation.
- Professionals United by Diabetes (PROUD).
- School of Health Science, University of Wales, Swansea.

**Executives from 271 patient groups gave advice during the first stage in designing a patient-friendly questionnaire (a QoL study conducted December 2006-January 2007)**

Respondent groups came from across England and Wales, and were varied in geographic remit.



The HAPPI panel’s aim was to develop an ambitious, user-friendly questionnaire that would allow comparative data to be collected across disease areas on quality-of-life (QoL) issues of relevance to patients. Seed-corn funding for the work came from Novo Nordisk, and was supplemented by PatientView.

The two-year project culminated in an article on the project’s methodology [A. Wyke, et al., ‘What is quality of life for patients?’, *Journal of Healthcare Management*, vol 14, no 7, July 2008, pp 280-287].

**A two-stage design methodology**

The HAPPI project adopted a two-stage approach to designing a patient-friendly questionnaire.

- (1) In stage one, senior executives of patient groups were surveyed (December 2006 to January 2007), and posed open-ended questions on patients’ understanding of QoL in the context of their medical condition. The groups were randomly selected from PatientView’s database of 14,000 UK NGOs (the database includes any organisation seeking to represent the interests of patients, parents, carers, or the public on health and healthcare subjects).

A diverse body of 271 organisations from across the UK took part in the online survey. They drew on various forms of funding (from industry to government), and represented people with disparate medical conditions [see charts on previous page, and below]. No condition predominated among the respondents’

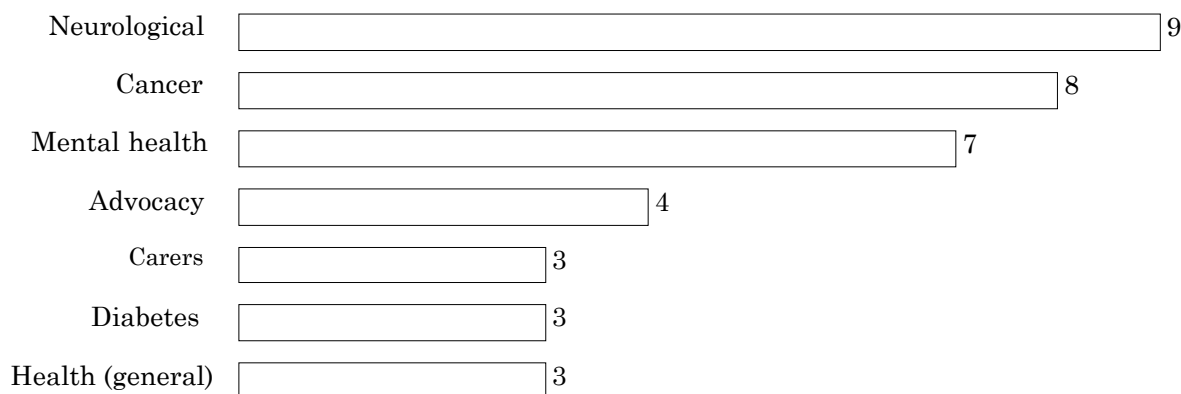
specialties, although 9% of the groups concentrated on neurological conditions.

The definitions of QoL factors offered by the 271 groups could be subsequently distilled down to 31 categories. For example, a definition provided by the Trafford Asian Women’s Network —“*To have a way of life, and be able to use medical facilities, without worrying about the financial consequences*”— was considered to fall into the following category: ‘Not being worried that financial considerations will prevent me from getting the medical treatment/care/ support that I need’.

The 31 unique QoL factors could be further divided into three ‘classes’ of definition:

- ✓ Access to, and excellence of, treatment and care.
- ✓ Physical wellbeing as a result of care.
- ✓ General outlook on life as a result of care.

**Respondent groups in the first stage of the design process represented the interests of a diverse array of people with different medical conditions or health problems**



**QoL priorities for the majority of patients with arthritis**

[Number of patients with arthritis = 97]

Rank	Factor	%
= 1	Being relatively free of pain and bodily discomfort	11
= 1	Not having to fight the system to receive medical care	11
= 1	Feeling that I can retain my independence	11
4	Getting the correct medical treatment/care	10
5	Feeling largely in control of my life	7
= 6	Coping with daily living in dignity	6
= 6	Being able to lead a normal (or near-normal) life	6

Although the definitions of QoL uncovered by the HAPPI project fall largely into line with observations made by other researchers collecting patients' perspectives on QoL, a key difference does emerge between the HAPPI project's results and those of other studies. The HAPPI project's measures are articulated in a way that patients themselves might express—and should, therefore, have more meaning to patients.

- (2) The second step of the methodology moved from patient groups to patients themselves. In an online survey, the project asked patients to consider the 31 factors supplied by the patient groups, and nominate the factor most important to them in improving their QoL as a result of their medical care.

Some 2,246 patients from across England and Wales took part in the survey. (An international arm of the study sampled the views of another 1,220 patients from 67 other countries.) The body of respondent patients was drawn from all age groups, lived in towns or rural areas, and occupied a full range of income brackets. 5% were non-white. More women than men answered the survey, but patients of different genders shared largely similar views.

The results from this second survey showed that while the vast majority of patients acknowledge the value of all of the 31 QoL factors, individual types of patients do differ in which QoL factors are most important to them. Thus, 11% of people with arthritis place freedom from pain and bodily discomfort as their main priority for achieving QoL as a

**QoL priorities for the majority of patients with cancer  
(of all types)**

[Number of patients with cancer = 177]

Rank	Factor	%
1	Getting the correct medical treatment/care/support	15
= 2	Being satisfied with the medical care I am receiving	7
= 2	Sufficiently skilled and expert healthcare professionals	7
= 2	Feeling sure that the doctor is listening to my opinions	7
= 5	Being able to lead a normal (or near-normal) life	5
= 5	Feeling largely in control of my life	5
7	Not having to fight the system to receive medical care	4
= 8	Knowing that scientists are working hard to find a cure	3
= 8	Coping with daily living in dignity	3
= 8	Feeling that I can accept my condition as a real fact	3

result of treatment and care; 11% insist that not having to fight the system for care is most important to them; and around 30% put retaining independence, or control of their life, or dignity, or the ability to lead a normal life as their most important QoL factors.

For 15% of patients with (all types of) cancer, the top QoL priority is “being sure that they are getting the correct treatment, care, and support”. Satisfaction with care, a listening doctor, and access to skilled professionals also rank highly among cancer patients’ QoL priorities.

According to Dr Wyke, one of the project’s peer reviewers remarked that the survey was surely only stating the obvious when it found that getting the correct treatment and care was the highest priority for cancer patients (and for some other patients). “Aren’t professionals trained to provide exactly that?”, commented the reviewer. They may be, Dr Wyke told the seminar audience, but getting the correct treatment, support, or care can still prove elusive for many patients. A Canadian patient with cancer who replied to the international arm of the study identifies one of the difficulties of access experienced by some patients:

“I believe that you should be able to have the best quality of life, and the treatment to make that possible—even if you only have a short time to live. You should have the right



to pain relief, and the best care to the end of your life, and not be told that these are a waste of money because there is no cure.”

Dr Wyke concluded her talk by reporting that the project’s two-stage methodology—in which patient groups design questionnaires for patients—has since been utilised in two further projects conducted by PatientView:

- *Patient Safety, Clinical Quality, and the Patient Experience of NHS Services in London*. Commissioned by NHS London and Deloitte, this project ran February-

March 2008. The survey gathered a broad range of the definitions that patients employ when they refer to the topic of patient safety, thereby allowing NHS London and Deloitte to clarify patients’ priorities on the subject.

- A study for the National Audit Office (NAO) about patients’ perspectives on how to improve services for people with rheumatoid arthritis (RA), running October 2008-January 2009.

### Questions to speakers

#### On patient surveys

Dr Alexandra Wyke was asked whether the types of patients who responded to the QoL survey could really be regarded as representative, given that they were recruited from patient organisations. After all, as many people know, the members of patient groups tend to be more active and vocal than most other patients.

Dr Wyke replied by pointing out that any patients who answer questionnaires are—irrespective of their background—already a self-selective sample. It is true, though, she added, that data may be skewed by the way in which patients are selected for a study. However, that is not to say that the views of survey respondents should be disregarded, she noted, but merely put in context.

#### On the application of PROMs in clinical settings

Dr Kirstie Haywood was asked the extent to which doctors/clinicians take PROMs seriously, and whether their everyday practice relies on the data provided.

Dr Haywood responded by observing that hundreds of questionnaires claim to measure PROMs. Selecting the appropriate one can be challenging. However, organisations like BUPA have been using PROMs (namely the SF36 questionnaire, to measure health status for different types of medical treatment and states of health) for over 10 years now, she said [<http://www.bupa.co.uk/healthsurveys/html/why/sf36.html>]. Dr Haywood also drew attention to the work of OMERACT, which has agreed to include PROMs such as fatigue as valid end-points to measure in clinical research.

### **The World Health Organization and quality of life**

Based at the University of Bath, Suzy Skevington is Director of the World Health Organization Centre for the Study of Quality of Life (WHOQOL Group), a collaboration dedicated to the cross-cultural understanding of quality of life (QoL) in health and healthcare. The WHOQOL project, which was initiated in 1991, now operates in 50 countries worldwide, including the UK [<http://www.bath.ac.uk/whoqol/about.cfm>].

Speaking at the ‘Outcomes in clinical research’ seminar, Professor Skevington noted that issues of QoL which are related to treatment and care inevitably came to the fore once healthcare systems began to position patients centre stage. The term QoL may be relatively new to the English language, she said, but it has resonance with the older, more traditional concept of ‘standard of living’. As of 1995, the WHO has defined QoL as:

“Individuals’ perception of their position in life, in context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns.”

From the outset, the WHOQOL collaboration set itself the goal of finding a mechanism for assessing QoL across all cultures—despite the fact that different parts of the world and different healthcare stakeholders (such as carers, clinicians, and patients) hold opposing views on what QoL involves. Over the years, the WHOQOL Group has developed a number of instruments that cover 25 facets of QoL in sick and well populations (facets related to physical health, psychological state, social relationships, and the environment).

These instruments have been tested rigorously worldwide, assessing QoL among the chronically ill, among caregivers of the ill and disabled, and among people living in highly-stressful situations (such as migrants). More recently, cross-cultural investigations have been used to evaluate health services, and to improve doctor/patient relationships.

One of the biggest barriers to the universal application of the WHOQOL tool is the use of language, and the need to translate questionnaires. A key element of the work undertaken by the collaborative, therefore, is a close study of concepts and semantics, so that they have greater equivalency across cultures. Professor Skevington stresses that this will “improve the measurement of clinical outcomes between the centres involved in multi-national clinical trials”.

Professor Skevington finished her talk by mentioning that the International Society for Quality of Life Research (ISOQOL) is discussing whether a declaration of personal QoL rights should be drafted.

# Patients as drivers of clinical research

Dr Diana Rose has used her own experiences of mental health problems to help shape future clinical research in the field of mental health. She co-heads a unique facility, the Service User Research Enterprise (SURE), at the Institute of Psychiatry, King's College, London. Part of her brief at SURE is to develop user-valued outcomes measures in mental health. Indeed, she is thought to be Europe's first senior lecturer in user-led research [<http://www.iop.kcl.ac.uk/departments/?locator=300>].

Echoing the words of Sir Iain, Dr Rose told the audience at the 'Outcomes in clinical research' seminar that randomised clinical trials (RCTs), considered the 'gold standard' in medicine, are nonetheless compromised by the fact that the outcomes they measure may not matter to people with a mental health problem. Such a failing is the result of academics and clinicians defining what is to be measured in a clinical study, not the users of mental health services.

People with a mental health problem occupy an exceptional position in the healthcare system, she declared—they can be treated against their will. This reality alone has prompted many mental health advocates to take an active interest in relevant clinical research. Yet, even here, they are disadvantaged. Most other types of patients have the opportunity to negotiate the outcomes of clinical research on a 'level playing field' with academics and researchers. People with a mental health problem find that the same is not always true for them.

The primary goal for the academics and clinicians who specialise in mental health problems is the relief of patients' symptoms. Users of psychiatric services, however, do not always share that aim. One example of a symptom that can be welcomed by some patients with a mental health problem is the 'high' occasionally experienced by people with bipolar disorder. This high can act as a stimulus to creativity. Similarly, some people with a mental health problem would rather tolerate certain symptoms than have to cope with the side-effects of toxic medication.

## About SURE

Most of the team of ten at SURE are, or have been, users of mental health services. SURE faces formidable challenges—not the least of which is the medical profession’s belief in medication to abate mental illness (an ethos that can run counter to patients’ own thinking on the matter). According to Dr Rose, difficulties occur, not only in devising ways of conducting research from a service-user perspective, but in ensuring that results do really bring about changes in treatment and care.

Since being founded in 2001, SURE has led systematic reviews (with emphasis on the consumer perspective) of electro-convulsive therapy (ECT) and new anti-depressant medication. The ECT review influenced 2003 guidelines from the National Institute of Health and Clinical Excellence (NICE) on gaining consent to ECT, and about giving treatment information.

Dr Rose described research at SURE as being focused on ways to improve clinical research methodology. The aim is to make it more user-friendly by recalibrating the power relations between researchers and researched, and to permit users to themselves become researchers who develop user-valued outcome measures.

Dr Rose explained that when tools to measure outcomes of relevance to people with mental health problems are designed, consensus is built among users. The following elements are involved in the processes of design:

- A **reference group** (including users with research expertise) defines the topic to be researched, and provides guidelines as to how goals might be achieved.
- **Focus groups** discuss their own experiences within the framework of the topic guide.
- The results of open discussions within the focus groups are analysed and categorised, and subsequently fed into the design of the questionnaire for patients (the questionnaire is the tool for measuring outcomes). The questionnaire is reviewed and fine-tuned by **expert panels**, composed of people who, again, have all received mental health treatments or services. Every effort is made to ensure that the language of the questionnaire is one familiar to service users.
- Around **40 people** assess the questionnaire for ease of completion and for comprehension.
- The **reference group** meets once again to discuss the construction of the questionnaire.

Throughout this process, the researchers (for instance, the focus-group facilitators) are themselves mental health service users. Results are passed on to participants in the design process.

The technique described above may seem complex, but it appears to work, advised Dr Rose, even for people with psychoses. Although no standards as yet exist for this

novel type of work, she added, the results are compared and contrasted with more traditional clinical outcome measurements. Thus far, the approach has been deployed in the following research areas:

- Continuity of Care (in press).
- Satisfaction with Cognitive Remediation Therapy for People with Schizophrenia (published).
- Satisfaction with Cognitive Behavioural Therapy for Psychosis.
- Experiences of Acute In-Patient Care.

Despite increased recognition of the importance of user-involvement in clinical research, opponents of the technique remain, signaled Dr Rose. Professor Peter Tyrer, editor of the *British Journal of Psychiatry*, for example, wrote in the *Psychiatric Bulletin* in 2002:

“There is a real danger that the engine of user initiatives in mental health services, although positive in principle, will accelerate out of control and drive mental health research into the sand.”

Professor Tyrer’s main objection appears to be that user-led research is not robust, said Dr Rose. The same reasoning surfaced at the 2004 European Network for Mental Health Service Evaluation (ENMESH) conference. This conference had a stream on user-led research. Critics of the user-led research approach insisted at the conference that the method relies on anecdotal evidence, and is carried out by people emotionally involved with the end result. One delegate even described user involvement in research as “just political correctness”. But, according to Dr Rose,

users make no pretence of being neutral in their research endeavors. Indeed, users are far more explicit about this fact than mainstream researchers, who have their own prejudices.

Dr Rose concluded that, in her opinion, the world ‘bias’ should be banished from research discourse, and all researchers should clearly specify where their vested interests lie. She believed that psychometrically robust measures can be developed from the perspective of service users. And that, she stressed, is a new form of so-called ‘participatory’ research.

### **Final discussions**

The seminar concluded with a wide-ranging debate about how patients, clinicians, and policymakers often interpret outcomes data differently. Peter Tugwell, Professor of Medicine at the University of Ottawa, and a member of the Organising Committee of OMERACT, cited one example—the case of Vioxx. This anti-arthritic was withdrawn from use in 2004 by regulators concerned about the risk of cardiovascular events associated with the drug. Yet, insisted Professor Tugwell, he has been told by many patients with arthritis that, after mentally balancing the risk of the drug's side effects with the great relief it offers, they had decided that they would be willing to take the drug if it were available.

The audience also discussed the degree to which patients' views are, or should be, incorporated into health policy decisions—particularly those related to research. Members of the audience indicated that patients can express themselves in many ways, but their views may get overlooked. Similarly, important research work conducted by charities and other non-profitmaking groups may be side-lined, due to the groups' difficulties in accessing peer-review systems. However, Professor Oliver pointed out that the Health Technology Assessment Programme run by the NHS National Institute for Health Research (NIHR) “has had a long record of public involvement for identifying important unanswered questions about treatments”.

Professor Tugwell argued that any search for consensus should make sure that the number of patient representatives outstrips medical professionals (the latter have a tendency to dominate discussions). By way of example, fears were aired by some within the audience that the UK government's PROMs agenda could be usurped by the clinical community, which various seminar participants insisted seem to be driving PROMs towards becoming more clinically-based (rather than user-led). Some members of the audience also acknowledged the difficulties of getting user-friendly patient questionnaires past the scrutiny of peer reviewers.

On a positive note, Professor Oliver noted that text-mining software is particularly valuable for identifying on the Internet patient-authored documents about topics of importance to them, and which need to be incorporated into research agendas.

Examples were also provided of the use of PROMs in GP clinics to form the basis of doctor/patient consultation.

**A seminar jointly organised by**

—The James Lind Alliance.

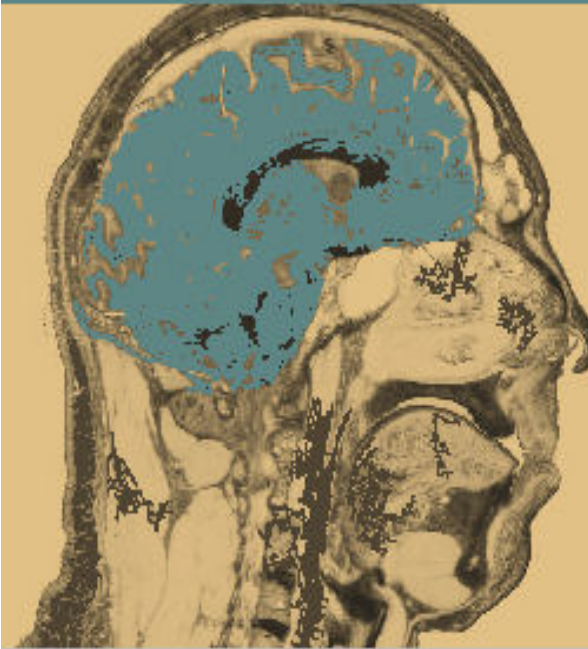
—The Social Science Research Unit, Institute of Education,  
University of London.

—The Royal College of Nursing Research Institute,  
University of Warwick.

**November 20th 2008**

## **Outcomes in clinical research**

**—whose responsibility?**



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