CORRESPONDENCE

Informed Consent

TO THE EDITOR: In their review article (March 2 issue),[1] Grady and colleagues suggest that technological advances could help to facilitate obtaining informed consent without an in-person meeting between participants and investigators. However, we believe that true informed consent needs to go beyond symbolic measures such as clicking blocks electronically or supplying a signature.

Without an in-person meeting, participants may feel coerced into participating without the researcher being aware of it. In addition to securing the privacy and confidentiality of participants, mutual trust and confidence must be built while sharing the emotions regarding fear and anxiety about uncertainty and unpredictability of the trial outcome.[2,3] We believe that in-person discussion is an imperative step in obtaining informed consent in most clinical trials.

Hyun G. Goh, M.D.
Sang W. Shin, M.D., Ph.D.
Korea University Medical Center
Seoul, South Korea
shinsw@kumc.or.kr

No potential conflict of interest relevant to this letter was reported.

1. Grady C, Cummings SR, Rowbotham MC, McConnell MV, Ashley EA, Kang G. Informed consent. N Engl J Med 2017;376:856-67.
2. Miles SH. Hippocrates and informed consent. Lancet 2009;374:1322-3.
3. Simpkin AL, Schwartzstein RM. Tolerating uncertainty — the next medical revolution? N Engl J Med 2016;375:1713-5.

DOI: 10.1056/NEJMc1704010

TO THE EDITOR: The electronic tools highlighted by Grady et al. may help to address the challenges of poor comprehension of research information resulting from complex and lengthy paper-based informed-consent forms. Such innovative strategies could be of paramount importance in the context of high illiteracy rates or a lack of standardized writing formats for the local languages.[1,2]

Although we agree that electronic tools could improve participants' comprehension, we are surprised that the inherent challenges that are posed by implementing such strategies in low-resource countries,[3] where an increasing number of clinical trials are taking place, were not discussed. We think that poor Internet access coupled with few Internet-enabled smartphones, along with concerns that electronic tools may weaken the element of human interactions that form the basis of research ethics, need to be considered. We believe that the overall acceptance and success of the electronic informed-consent tools in the African context will ultimately depend on a well-balanced and tailored combination of some traditional tools, technology, and human elements.[4]

Muhammed O. Afolabi, M.D., Ph.D.
London School of Hygiene and Tropical Medicine
London, United Kingdom
Alberto L. García-Basteiro, M.D.
Centro de Investigação em Saúde de Manhiça
Maputo, Mozambique
alberto.garcia-basteiro@manhica.net

No potential conflict of interest relevant to this letter was reported.

1. Afolabi MO, Okebe JU, McGrath N, Larson HJ, Bojang K, Chandramohan D. Informed consent comprehension in African research settings. Trop Med Int Health 2014;19:625-42.
2. Villafranca A, Kereliuk S, Hamlin C, Johnson A, Jacobsohn E. The appropriateness of language found in research consent form templates: a computational linguistic analysis. PLoS One 2017;12(2):e0169143.
3. Kalabuanga M, Ravinetto R, Maketa V, et al. The challenges of research informed consent in socio-economically vulnerable populations: a viewpoint from the Democratic Republic of Congo. Dev World Bioeth 2016;16:64-9.
4. Afolabi MO, McGrath N, D'Alessandro U, et al. A multimedia consent tool for research participants in the Gambia: a randomized controlled trial. Bull World Health Organ 2015;93:320-328A.

DOI: 10.1056/NEJMc1704010

THE AUTHOR REPLIES: Goh and Shin highlight the value of in-person discussion in the informed-consent process for most clinical trials. My colleagues and I agree that in-person discussions are the most appropriate method for informed consent for the majority of clinical trials. It could very well be difficult to assess voluntary choice and evaluate body language without meeting a potential participant, as noted in Table 1 of our article, but voluntariness is challenging to evaluate in any case.[1] Nonetheless, as emphasized, the

appropriateness of particular informed-consent strategies crucially depends on context, which includes at least the research question, the type of interventions and data being collected, the populations to be included, where they live, their literacy level, and their access to and familiarity with technology. For example, some large pragmatic trials currently enroll thousands of persons from various locations without the need to visit a health care facility or meet in person with an investigator. For certain pragmatic trials, especially those with little to no added research risk, a requirement for in-person informed consent is unnecessary as long as participants have the information they need to make decisions about participation and can choose whether or not to participate.[2] Similarly, informed consent for secondary research with data and biospecimens might appropriately be remote, regardless of whether it is broad or study-specific.

Afolabi and García-Basteiro mention that the choice of technological approaches to informed consent for a given trial has to account for the availability of, and access to, the planned technologies. Clearly, such availability and access can vary dramatically, and not just between low-resource and high-resource countries. Disparities in familiarity and comfort with technology should also be considered. My colleagues and I tried to capture these ideas briefly by emphasizing that context always matters and by recognizing that "informed consent will require the creative use of technologies that are simple, easy to use, and in widespread and common use." Widespread and common use was intended to refer to participants who are likely to be enrolled in the trial, regardless of where they live. Respectful and effective informed-consent strategies depend on tailoring methods appropriate for the context and potential participants.[3]

Christine Grady, R.N., Ph.D.

National Institutes of Health Clinical Center
Bethesda, MD
cgrady@nih.gov

Since publication of her article, the author reports no further potential conflict of interest.

1. Appelbaum PS, Lidz CW, Klitzman R. Voluntariness of consent to research: a preliminary empirical investigation. IRB 2009; 31:10-4.
2. Jones WS, Roe MT, Antman EM, et al. The changing landscape of randomized clinical trials in cardiovascular disease. J Am Coll Cardiol 2016;68:1898-907.
3. Wendler D. How to enroll participants in research ethically. JAMA 2011;305:1587-8.

DOI: 10.1056/NEJMc1704010