Physicians should declare financial incentives for recruiting minority ethnic patients into clinical trials

Mistrust may explain why non-white people are under-represented in clinical trials despite apparent willingness. Arch G Mainous III suggests doctors who recruit such patients should declare their interests.

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The National Institutes of Health in the United States and others recognise the importance of adequate representation of non-white ethnic minorities in clinical trials and require that investigators outline a recruitment plan in grant proposals. Recruiting adequate numbers of ethnic minority people into trials is also important in countries such as the United Kingdom, where funding agencies do not currently require it. Such inclusion is necessary to ensure that evidence has the widest applicability as well as for understanding healthcare delivery and quality of care among these groups.

Unfortunately, non-white people tend to be under-represented in healthcare research, even though they are reported to be as willing as white people to participate. Mistrust is the most common barrier to participation identified in studies of non-white minority patients’ participation in research, and efforts to overcome this may be key to reconciling the apparent incongruence between stated willingness to participate and low participation.

Strong patient-physician relationships, and patients’ trust in their physicians, are critical to the delivery of healthcare for all patients, but especially those from minority ethnic groups. Patients are more likely to agree to participate in trials if they trust their physician and he or she recommends they take part. Patients trust their physician to act in their best interests and assume that medical researchers also act in their interests and not just those of the investigators.

Trust in their personal physician seems to be a particularly important determinant of enrolment of non-white people, partly because they tend to have less trust in medical researchers than do white people. Less educated and older non-white people tend to have the least trust in medical researchers.

Physicians with large populations of non-white patients, regardless of their own ethnic group, tend to mirror their patients’ attitudes and trust medical researchers less, illustrating the role of physicians acting in their patients’ interests. Physicians build on the trust inherent in the patient-physician relationship and become advocates for their patients as they contemplate vouching for the investigators to their patients. Several strategies have been suggested for recruiting people from ethnic minorities and particularly for building trust. Building trusting relationships between physicians and ethnic communities takes respect and reciprocity, including paying attention to language or other communication barriers. Another strategy is to use personal physicians as recruiters or investigators.

Incentives to recruit more non-white people into clinical trials may include direct payments for each person recruited or, less directly, funding agencies may threaten to withdraw grants from trials with inadequate recruitment. So an investigator’s income or career may be at risk unless he or she recruits sufficient non-white people. A recent review of UK guidelines did not endorse paying healthcare professionals to recruit patients. Mandates to include more non-white people in trials may put pressure on investigators, and in particular personal physicians as recruiters, to convince their ethnic minority patients to participate. It is unknown whether such pressure affects physicians’ judgment. Might it bias the physician-investigator towards acting in his or her best interest rather than that of the patient? Given the trust and power in the patient-physician relationship, at what point does the physician’s encouragement to participate become coercion?

These incentives may affect trust between patients from minority groups and physicians. One solution is for physicians to disclose information about financial incentives or other implications of them enrolling the patient. A practical strategy could be for ethics committees to require physicians to declare these financial incentives.

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interests when obtaining informed consent from research participants.

One study found that patients who participated in trials thought that they should be given full information about payments to the physician, and they thought that physicians would be reluctant to disclose this information because their motives may be questioned.\(^1\) Evidence suggests that trust between patients and physicians increases when financial interests in recruitment are disclosed.\(^13\) Although it has been argued that knowledge of such incentives doesn’t really affect overall recruitment, it is unclear how representative this evidence is of the attitudes among minority groups.\(^13\) For example, in several surveys of patients’ perceptions of the importance of disclosure less than 3% of those asked were black.\(^14\) 15

Personal physicians acting as recruiters to trials should disclose all direct and indirect financial incentives so that patients can make an informed decision—and so that they know that physicians may be acting not only in the patient’s best interest but also in their own interest. It may take a little longer to explain, and could be an awkward conversation, but it should be worth it to maintain a positive patient-physician relationship, to deliver good healthcare, and to do good science.

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