

2. Conceptual framework—setting the scene for ‘protection’ and ‘promotion’

I. INTRODUCTION

Human health research, which can be defined as research into matters relating to people’s physical or mental health, is a formalized, institutionalized, and regulated activity, replete with actors, rules, tools, policies, and diffuse sets of social constraints. Researchers who wish to gather data, investigate questions, test hypotheses, and build new generalizable knowledge on topics that involve human participants confront at the earliest stages of their project design the application of abstract ethical principles such as respect for persons, social value, beneficence, and justice, not to mention rules regarding informed consent and confidentiality. Additionally, researchers confront a panoply of law and regulation. When it comes to health research involving humans, determination of its ethical acceptability has taken a particularly regulated, technocratic, and structured form, with specific groups of individuals wielding power to decide whether a research project may proceed on ethical grounds. This group is known as a research ethics committee (REC), which is also known as an institutional review board (IRB) and research ethics board (REB).

This book will explore the mandate and operation of one particular type of REC in the UK, the NHS REC, drawing on both governance instruments and policies and original empirical research. This chapter begins the process by querying whether the practices of these RECs align with their recently established regulatory mandate—as set out in instruments promulgated by the UK government, devolved administrations, and regulatory bodies—which has modified the regulatory environment involving human health research. In particular, it explores a shift from a protectionist model that has been seen by some as paternalistic, with regulators disproportionately focusing on research risks in comparison to research benefits and inexplicably road-blocking otherwise ethical research, to a more broadly facilitative model, undergirded by law, that

could be called ‘next-generation’ in that it seeks to foster an environment that both protects research participants *and also facilitates* responsible health research through proportionate risk-based regulation and coordinated alignment of ethics review and other regulatory processes. Seemingly invigorating a public interest aim of health research oversight—to promote valuable research that advances human health for the benefit of the public—this next-generation regulation has emerged most clearly in the last decade (through policies and guidelines) and is reflected most overtly in the statutory Care Act 2014 and in the body that exemplifies this new way of regulating health research—the HRA.

This chapter raises the question of whether the roles and practices of RECs are shifting in compliance with this next-generation regulation, which was driven foremost by persistent criticism from research communities (e.g. academic, industry) regarding the perceived clogged regulatory space of ‘human subjects research’. As such, I query whether modifications to statutory law and central regulatory authorities ‘trickle down’ to the day-to-day practices of RECs.

To begin this exploration, I first provide an overview of the UK REC system.

II. AN OVERVIEW OF THE UK REC SYSTEM

RECs serve as gatekeepers of research involving humans. While the characterization of RECs as ‘gatekeepers’ is not uncontroversial,¹ I contend that they are gatekeepers in that they serve to control access to the potentiality of research involving humans, and as such occupy a central position in research governance. Governments around the world have delegated to RECs the authority to decide, through a regulatory ‘event licensing’² system and in some cases on the pain of sanction,³ whether or not any given proposed research project involving humans (or their data or tissue) is ethical and consequently appropriate to undertake or to continue. RECs are, therefore, ‘discretionary bodies with the power to apply the principles of research ethics, and the rules relating to particular fields of experimentation on human subjects, to research

¹ See e.g. Nathan Emmerich, ‘When Is a REC not a REC? When it Is a Gatekeeper’ (2016) 12 *Research Ethics* 234.

² Carl Schneider, *The Censor’s Hand: The Misregulation of Human-Subject Research* (MIT Press 2015) 33.

³ See e.g. The Medicines for Human Use (Clinical Trials) Regulations 2004, regs 49, 52.

proposals and research in progress’.⁴ Largely self-regulatory creations that first arose in the United States (US) in the mid-20th century in response to both research scandals and concerns about institutional liability (as explored in the next chapter), RECs have evolved from ad hoc, unstructured committees of peer reviewers in a few hospitals—fellow physicians or biomedical researchers assessing the ethical acceptability of a proposed project—to institutionalized, regulated bodies of diverse members existing worldwide, prospectively reviewing, deciding upon, and, to a limited degree, monitoring the ‘ethical acceptability’⁵ of all types of research involving humans, from epidemiological or observational studies to clinical trials. As the leading international ethics guideline on health research, the Declaration of Helsinki, states: ‘The research protocol must be submitted for consideration, comment, guidance and approval to the concerned research ethics committee before the study begins.’⁶ RECs regulate not just the ethical acceptability of health research, then. Because of their gatekeeping and monitoring role, they regulate very much the production and use of health research knowledge itself through *ex ante* control of which research is approved, which research questions can be asked, and how they may be answered.

The UK has a hybrid, and one might say uncoordinated, system of RECs. Some are institution-based. Others are location or region-based, and some are centralized, covering the whole country. Several different types of RECs exist. They can be split into two main categories of non-NHS RECs (e.g. higher education institution RECs) and NHS RECs. In this book, I address only the latter.

2.1 NHS RECs

NHS RECs, also known more formally as ‘RECs within the UK Health Departments’ Research Ethics Service’ (RES), are region-based committees. Officially overseeing a local health area within the NHS system, in

⁴ Paul McNeill, *The Ethics and Politics of Human Experimentation* (CUP 1993) 205.

⁵ See e.g. Council for International Organizations of Medical Sciences, *International Ethical Guidelines for Health-Related Research Involving Humans* (Council for International Organizations of Medical Sciences 2016), Guideline 23: ‘All proposals to conduct health-related research involving humans must be submitted to a research ethics committee to determine whether they qualify for ethical review and to assess their ethical acceptability [...]’ [hereinafter CIOMS Guidelines].

⁶ World Medical Association, *Declaration of Helsinki* (World Medical Association 2013), para 23.

practice they operate within a centrally administered system that enables them to review research applications and provide an ethics opinion on health research involving humans in the NHS taking place anywhere in the UK. The Care Act 2014 defines an NHS REC as:

a group of persons which assesses the ethics of research involving individuals; and the ways in which health or social care research might involve individuals include, for example—(a) by obtaining information from them; (b) by obtaining bodily tissue or fluid from them; (c) by using information, tissue or fluid obtained from them on a previous occasion; (d) by requiring them to undergo a test or other process (including xenotransplantation).⁷

Across the UK, 86 NHS RECs review approximately 6000 research applications each year that seek to involve potential research participants (including patients) who are in the NHS system.⁸ There are 2 RECs in Northern Ireland; 7 in Wales; 11 in Scotland; and 66 in England (including the National Social Care REC in London). Formally existing since 1991 (but as will be discussed in Chapter 3, informally existing prior to this), they are committees of between 7 and 18 individuals (one-third of whom must be ‘lay’⁹) who are independent of research sponsors,¹⁰ funders, and investigators, and serve to opine on the ethical acceptability of research involving NHS staff, or patients and/or their tissue and data, among other kinds of health-related research.¹¹ Currently,

⁷ Care Act 2014, s 112(2) (emphasis added).

⁸ Health Research Authority, ‘Performance Report 2018/19’ <www.hra.nhs.uk/about-us/what-we-do/annual-report/annual-report-and-accounts-201819/performance-report/> accessed 15 October 2019.

⁹ The UK classifies REC members as either ‘expert’ or ‘lay’, the latter category meaning ‘a mixture of people who reflect the currency of public opinion’, and the former category meaning people who ‘have relevant formal qualifications or professional experience that can help the REC understand particular aspects of research proposals’ (i.e. physicians and other health care professionals). Lay members ‘are people who are independent of care services, either as employees or in a non-executive role’. See GAfREC paras 1.2.2, 4.2.3. The HRA has decreed that half of the lay members must be ‘lay plus’ members, who are people who have never been care professionals, researchers in a care field, or chairs, members, or directors of care service bodies or organizations providing care.

¹⁰ Research sponsors are the organizations responsible for the management and conduct of the research.

¹¹ GAfREC para 2.3.

there are over 150 staff members (e.g. REC Managers, HRA Regional Managers) and over 1000 volunteer members of NHS RECs across the UK.

Depending on where their REC is situated, NHS REC members are appointed by the HRA in England, the Business Services Organisation through the Office for Research Ethics Committees Northern Ireland (ORECNI) in Northern Ireland,¹² and the local Health Boards in Scotland and Wales.¹³ Each REC has a Chair, a Vice Chair, and an Alternate Vice Chair, and is coordinated by a Manager (as well as an Assistant, who, along with REC Managers in England, may be responsible for several RECs).¹⁴ Unlike in other countries, there is no requirement that a REC specifically include a lawyer, theologian, ethicist, patient advocate, or ‘community member’.

Though only some kinds of health research must obtain prior REC approval under the law, institutional, journal, and regulatory policies confirm that few health research projects may proceed without an NHS REC receiving and reviewing the research protocol and attendant documents, and providing a positive (i.e. favourable) opinion. As the standard operating procedures (SOPs) for NHS RECs state: ‘The policy of the UK Health Departments is that the operating procedures required by the EU Directive and the Clinical Trials Regulations should also apply in general to the review by RECs in the UK of all other health and social care research reviewed under GAFREC.’¹⁵ A 2011 Academy of Medical Sciences (AMS) report also notes the wide reach of these RECs: ‘Because positive opinion from a REC is required for all studies that take

¹² Office for Research Ethics Committees Northern Ireland <www.hscbusiness.hscni.net/orecni.htm> accessed 15 October 2019.

¹³ Even though RECs in Scotland and Wales may cover more than one Health Board, or so-called ‘regions’ (e.g. the two RECs based in Edinburgh, known as South East Scotland REC 1 and 2, officially cover both NHS Lothian and NHS Borders, together known as the South East Scotland region in the NHS Research Scotland node), generally the bigger Health Board (in terms of resources) will make the appointment. As the GAFREC state, ‘Where an NHS Scotland Health Board is not a REC appointing authority, they must contribute proportionately to the running costs of their NHS Research Scotland nodal research ethics service’ (GAFREC 37).

¹⁴ GAFREC para 4.2.13.

¹⁵ Health Research Authority, *Standard Operating Procedures for Research Ethics Committees* (Version 7.4, Health Research Authority 2019) [hereinafter REC SOPs], Introduction.

place in the NHS, this review forms a core component of the regulation and governance pathway.¹⁶

Common categories of NHS REC review include:

- Clinical Trials of an Investigational Medicinal Product (CTIMP), including NHS Phase 1 CTIMPs in healthy volunteers;
- research involving medical devices;
- qualitative health research involving participants identified in the context of, or in connection with, their past or present use of the NHS or social care services;
- health-related research involving children, adults lacking capacity, or prisoners; and
- the establishment of research tissue banks and research databases.

The research applicants who must submit a REC application would therefore include, for example, pharmaceutical and medical device companies; health care professionals in the NHS; academic researchers at higher education institutions (including postdocs and students); and prison health researchers. Thus, whether a researcher is conducting clinical, epidemiological, or even law and social science-driven health research, if the proposed project involves NHS patients or service users as participants, the researcher must apply for NHS ethics approval through application to a REC. A favourable opinion from a REC is not a licence to immediately begin research. Researchers must also obtain research governance permission (i.e. assessment of governance and legal compliance) from each relevant NHS management authority. In England and Wales, this is done centrally through HRA and Health and Care Research Wales (HCRW) Approval and applies to all project-based research taking place in the NHS in England and Wales. Projects led from Scotland or Northern Ireland must apply through the appropriate NHS/HSC permission process for the relevant lead nation.

As noted, a centralized attitude is taken to managing RECs in the UK, compared to a more 'devolved' institution-based approach seen in other jurisdictions such as Canada or the US. NHS RECs are overseen by central regulators, including the United Kingdom Ethics Committee Authority (UKECA) for those RECs 'recognized' to give an ethics opinion on a CTIMP. In England, RECs are overseen by the RES, a service under the auspices of the HRA, which itself is an arm's-length

¹⁶ Academy of Medical Sciences, *A New Pathway for the Regulation and Governance of Health Research* (Academy of Medical Sciences 2011) 76.

body situated in England’s Department of Health and Social Care. The HRA’s RES operates five offices across England (London, Bristol, Nottingham, Manchester, and Newcastle), which in turn manage RECs more or less within their region. Each office is led by a RES Regional Manager.

There are equivalent RESs in the three other nations. In Scotland, the Health Boards function as the HRA equivalent, while four Scientific Officers and the Chief Scientist Office (CSO) function as the equivalent for the RES for RECs within NHS Scotland. (Much more will be said about these Scientific Officers in later chapters.) There are equivalent bodies in Northern Ireland (ORECNI) and Wales (Health and Care Research Wales Ethics Service), but as will be seen, in practice, the HRA through its RES has taken a leading (and coordinating) role for managing RECs throughout the UK, albeit to varying degrees and with varying degrees of success.

NHS RECs tend to convene once per month, up to 10 or 11 times per year, for a ‘full committee’ meeting that can run anywhere from two-and-a-half to five hours. The majority of the meeting time is spent reviewing new applications, which generally are capped at six per meeting (the norm is between four and six per meeting). In-between the monthly meetings, a smaller group of REC members discuss up to four new applications submitted for ‘Proportionate Review’, that is, applications submitted for a quicker review because they are said to raise ‘no material ethical issues’). These discussions usually take place via emails or teleconference. A smaller group of REC members (usually led by the Chair) also meet each month outside the formal monthly meeting to discuss ‘substantial amendments’ submitted by researchers concerning their applications already approved by the REC. For full review, RECs are required to provide a final opinion within 60 calendar days of receipt of a valid application, and a provisional opinion within ten working days of the application’s review at the meeting.¹⁷ RECs are required to provide an opinion on a Proportionate Review application within 21 calendar days of receipt of a valid application.¹⁸ Summaries of research and the

¹⁷ GAfREC para 3.2.9. If the REC renders a ‘provisional’ opinion requesting further information, the 60-day (for a non-Proportionate Review application) or 21-day (for a Proportionate Review application) clock is suspended until the information is received.

¹⁸ REC SOPS para 4.1.

REC opinion (including those that are unfavourable) are available on the HRA website approximately 90 days after the REC opinion.¹⁹

While NHS RECs handle a range of health research studies, there are in fact two broad categories of committees. First, some of these RECs are so-called ‘recognized’ RECs, that is, legally recognized by UKECA to give an ethics opinion on a CTIMP to be undertaken anywhere in the UK. These RECs may review CTIMPs of either ‘Type 1’ (healthy volunteers anywhere in the UK) or ‘Type 3’ (patients anywhere in the UK), or both. The second category of RECs are so-called ‘authorized’ RECs, which means that they are established under the Governance Arrangements for Research Ethics Committees (GAfREC), but are not recognized by UKECA, and therefore cannot review CTIMP applications. Since 2007, all NHS RECs are subject to an accreditation scheme now managed by the HRA. Some RECs also have specialist expertise (known as ‘committee flags’) in areas such as research involving children, research involving prisoners, the establishment of research tissue banks, qualitative research, or research involving adults lacking mental capacity. A smaller category of RECs has been recognized by UKECA for the review of gene therapy studies or stem cell clinical trials (currently four RECs have such recognition). Proposed research falling within any of these areas is steered towards RECs that are ‘flagged’ to review such research.

Having provided a brief overview of NHS RECs, I now turn to explore their roles.

III. THE ROLES OF RECs

As will be further explained in Chapter 3, RECs are not, by and large, creatures of statute. Rather, they were created informally by the UK health research community in the 1960s, foremost to ensure British researchers could continue to receive funding from the US federal government following that country’s newly enacted policy of institutionalized IRB review.²⁰ RECs were also created, however, in response to private and public concerns about participants’ safety in health research,

¹⁹ Health Research Authority, ‘Research Summaries’ <www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/> accessed 15 October 2019.

²⁰ Adam Hedgecoe, “‘A Form of Practical Machinery’: The Origins of Research Ethics Committees in the UK, 1967–1972” (2009) 53 *Medical History* 331.

and in response to general guidance from both the Royal College of Physicians of London and the Ministry (later Department) of Health encouraging their formation in every hospital.²¹ Thus, RECs have developed through varying forms of non-statutory regulation, namely policy, guidelines, and custom. Even today, no UK law clearly defines the roles of RECs (other than a high-level statement found in, for example, the Clinical Trials Regulations 2004 or the Care Act 2014), nor their procedural and substantive aspects, nor their legal status. Instead, the roles must be inferred through statutes as well as through interpretation of policies and guidelines.

3.1 Primary Role: Participant Protection

RECs, and arguably some of their individual members as well, perform several roles. The primary role is to protect the health, welfare, and dignity of research participants. A REC does this by issuing a single, independent opinion of a research application, set within a regulatory framework and, more broadly, a legal architecture. To quote the GAFREC, RECs aim to ensure ‘that any anticipated risks, burdens or intrusions will be minimised for the people taking part in the research and are justified by the expected benefits for the participants or for science and society’.²² As the GAFREC further state emphatically: ‘Whatever the research context, the interests of participants come first. Their dignity, rights, safety and well-being must be the primary consideration in any research proposal, as well as in REC review.’²³ In other words, a REC must act to safeguard research participants and minimize risk of harm to them. They do this by means of anticipatory avoidance—serving as independent watchdogs of projects and as gatekeepers of ethical conduct in research, rendering an opinion that seeks to avoid or at least mitigate any harm to participants.

This primary ‘risk minimizing’ or ‘participant safeguarding’ role is crucial to understanding the linkages between RECs, other health research regulators, researchers, participants, science, and society. RECs ostensibly engage in a variety of prospective inquiries, tests, and decision-making processes to determine whether a research project is ‘ethical’ and whether potential research participants are sufficiently

²¹ McNeill, *Human Experimentation* (n 4) 66–7. See also Julia Neuberger, *Ethics and Health Care: The Role of Research Ethics Committees in the United Kingdom* (King’s Fund Institute 1992) 9.

²² GAFREC para 1.2.2.

²³ *ibid* para 3.2.1.

protected. This role has been constant, to varying degrees, in RECs since their creation and serves to assuage society that science will proceed in a responsible manner. This, then, can be seen as a variation of a public interest aim: the public has an interest in seeing its constituent members (specifically research participants, be they volunteering healthy individuals or patients) sufficiently safeguarded against harm from research endeavours. Undertaking this primary role also suggests that the process effectively results in an ‘ethical covenant’, whereby the REC must trust that, following their approval and the research that eventually gets underway, the researchers will proceed as they have promised to do. Indeed, as we will see, beyond the expectation of a filing by a researcher of the completion of an annual progress report and submitting any substantial amendments to the project, there is limited power for a REC to monitor researchers following initial approval of the project.²⁴ This suggests an unmet need by regulatory actors—be they RECs or others—to steward researchers as they move past the approval stage and through the research lifecycle.

3.2 Secondary Role(s): Research Promotion

Protection of research participants may be RECs’ primary role, but crucially, they have also always performed secondary roles. One such role is a variation of the public interest aim: RECs have an obligation to society to facilitate ethical and socially valuable research. Similarly, RECs also have an obligation to researchers, namely through treating researchers’ proposals with respect and due consideration and enabling their ethical research. If most forms of research are seen as a public good and a morally valuable activity that pursues knowledge and innovation serving humanity, RECs serve not just to protect research participants from being exploited, exposed to excessive risks, or injured; they also serve to evaluate research for its putative societal benefit alongside participant protection. So, in some sense—and as will be explored empirically in later chapters—RECs engage in a value weighting system of protection and promotion. This said, the GAFREC indicate that these roles are not equal, but rather secondary, even placing ‘science and society’ under a separate heading and below the heading ‘protection of research participants’:

²⁴ GAFREC paras 3.2.15–3.2.17.

Science and society

RECs act primarily in the interests of research participants. The interests of researchers and research *are always secondary* to the dignity, rights, safety and well-being of people taking part in research. RECs take into account the interests and safety of the researchers, as well as the public interest in reliable evidence affecting health and social care, and enable ethical and worthwhile research of benefit to participants or to science and society.²⁵

Such a ‘role hierarchy’ or ‘principle hierarchy’, as it were, aligns with international statements on research ethics, including the European Union’s (EU’s) Good Practice Directive,²⁶ the Council of Europe’s Convention for the Protection of Human Rights and Dignity of the Human Being (Oviedo Convention),²⁷ and the Declaration of Helsinki. This does not foreclose a proportionate or other kind of approach to account for the value of participant protection and the value of research. Indeed, no guidelines or regulations for RECs exhort them to have regard *solely* for the rights, interests, and welfare of participants. What it does suggest, though, is that the goals of research and the researcher, while important, should always be secondary to the dignity, rights, and well-being of the research participant.

IV. AMBIGUITY IN THE ROLE HIERARCHY

Despite the GAfREC’s text, the role hierarchy of RECs in the UK has long been ambiguous. In 1984, for example, the Royal College of Physicians of London (RCP) issued a highly cited document, *Guidelines on the Practice of Ethics Committees in Medical Research* (‘RCP Guidelines’), which served as a much-needed source of information and opinion on a range of matters concerning the procedures of RECs, with the aim of standardizing them. The objectives of RECs, according to the Guidelines, were ‘to facilitate medical research in the interest of society,

²⁵ GAfREC para 3.2.2 (emphasis added).

²⁶ See Commission Directive 2005/28/EC of 8 April 2005 laying down principles and detailed guidelines for good clinical practice as regards investigational medicinal products for human use, as well as the requirements for authorization of the manufacturing or importation of such products [2005] OJ L91/13, ch 2, s 1, art 2 (‘The rights, safety and well being of the trial subjects shall prevail over the interests of society’).

²⁷ Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine (1997), art 2.

to protect subjects of research from possible harm, to preserve their rights, and to provide reassurance to the public that this is being done. Committees also protect research workers from unjustified attack.²⁸ Elsewhere, the RCP Guidelines stated that ‘it is important [for RECs] to be continuously aware of the need to avoid impeding good medical research. The Committee should indeed seek to facilitate good research’.²⁹ This statement was retained in future editions and arguably strengthened: the latest edition of the RCP Guidelines from 2007 states emphatically that ‘RECs have a duty to encourage important ethical research’.³⁰

Similarly, informal guidance for REC members stresses a dual role that involves some kind of balancing. For example, the sixth edition of the *Manual for Research Ethics Committees*, last published in 2003, states that:

Members of Research Ethics Committees have the responsibility of ensuring that medical research on humans is conducted in an ethical manner. In order to fulfil this function, Research Ethics Committees must engage in reasonable discussion and consideration of the ethical issues in each of the research proposals they have to review. This is demanding and time-consuming work, and the responsibilities entailed are considerable. *On the one hand* there is the need to contribute to the evidence base upon which modern medicine is based, *on the other* is the need to protect those who participate in the research process.³¹

As discussed more fully in the next chapter, the language of ‘protection and promotion’ has been instantiated in statutory regulation such as the Care Act 2014 and operationalized in the mandates of the HRA and in the mandates of RES offices across the four nations. For instance, HRA guidance for potential REC members states: ‘The key duty of a REC is to protect the interests of research participants whilst at the same time facilitating ethical research.’³² The claim that RECs equally serve to

²⁸ Royal College of Physicians, *Guidelines on the Practice of Ethics Committees in Medical Research* (1st edn, Royal College of Physicians 1984) 1.

²⁹ *ibid* 2.

³⁰ Royal College of Physicians, *Guidelines on the Practice of Ethics Committees in Medical Research with Human Participants* (4th edn, Royal College of Physicians 2007) 4.

³¹ Sue Eckstein (ed), *Manual for Research Ethics Committees* (6th edn, CUP 2003) xvii.

³² Health Research Authority, ‘Information for Potential Research Ethics Service Committee Members’ <www.hra.nhs.uk/documents/1025/standard-application-pack-rec-members.pdf> accessed 16 October 2019.

facilitate ethical research—perhaps even as a duty if we interpret the 2007 RCP Guidelines suggesting such—establishes a different message regarding the regulatory role of RECs in health research, as seen in both the literature and in documents such as the GAfREC, and arguably a message that is more pronounced than in other countries.

4.1 To Protect *and* (Equally) Promote?

It could be said that regulation is by its nature designed to affect behaviour of some kind (whether to restrict or to enable it), and therefore in some sense RECs have always, even if indirectly, been implicated in the facilitation of *ethical* health research. By considering, commenting on, guiding, and approving research studies that are well-designed scientifically and in accordance with law and established rules and principles of ethical conduct, RECs do promote a certain desired kind of behaviour, and this is what makes them regulators. Yet, even if regulation is, at its essence, about steering and therefore affecting social behaviour, critical questions still remain regarding: (1) how the interplaying roles of participant protection and research promotion might influence REC performance and decision-making, and (2) whether there might be regulatory misalignment between some of the instruments specifically for RECs—emphasizing participant protection—and regulatory instruments governing central regulators of health research and RECs themselves—imposing ethical research promotion—that impacts the overall quality and effectiveness of health research regulation.

As I have noted, that the UK emphasizes both protection and promotion is not new. For years, the country has held in some of its regulations and policies that RECs aim to facilitate (ethical) health research. The guidelines for RECs first emanated from the health research-promoting Royal College of Physicians in 1984. Then, as now, there was scholarly concern that ‘the British guidelines have tipped the balance too far in the direction of the interests of researchers and have not given sufficient emphasis to the protection of subjects’.³³ Then, as now, there was a concern that ‘committee members are confused by a perceived conflict between the requirement to facilitate research and their need to be critical of research’.³⁴

³³ Paul McNeill, ‘Research Ethics Review in Australia, Europe, and North America’ (1989) 11 IRB: Ethics and Human Research 4, 5.

³⁴ McNeill, *Human Experimentation* (n 4) 67, citing the study of REC members conducted by Julia Neuberger. See Neuberger (n 21) 44 (‘There is ambivalence arising from the sense that REC members should be supporting and

Moreover, several international (non-legal) policy instruments also suggest a dual role of protection and promotion for RECs.³⁵ For example, Canada's Tri-Council Policy Statement for ethical conduct for research involving humans states: 'The importance of research and the need to ensure the ethical conduct of research requires both researchers and [REC] members to navigate a sometimes difficult course between the two main goals of providing the necessary protection of participants and serving the legitimate requirements of research.'³⁶ Similarly, New Zealand's National Ethics Advisory Committee states that the ethics review system should '[f]acilitate research and innovative practice that contributes to knowledge and improved health outcomes' and '[p]rotect participants in health and disability research and innovative treatment'.³⁷

So, what is different? In short, I argue it is the legal embeddedness of research promotion. The research promotion role has moved 'up the ladder' in the regulatory framework for RECs and in the regulation of health research, to implementation in law, most pointedly in the Health and Social Care Act 2012 and Care Act 2014. What was once guidance has now become legal rule. To date, we do not really know the practical impact, if any, of this explicit legal shift, especially on RECs. At this preliminary, scene-setting stage, however, we can speculate that several different processes are at play in this shift.

4.2 Ethical, Political, and Regulatory Processes

Determining the ethical acceptability of research is not just a complex and amorphous ethical process; it is also a political process. REC members may employ discursive strategies to convince other members of

facilitating research rather than criticising it, and from the knowledge that RECs have inadequate powers, and often insufficient status, within their [District Health Authorities]’).

³⁵ Holly Fernandez Lynch and others, 'Of Parachutes and Participant Protection: Moving Beyond Quality to Advance Effective Research Ethics Oversight' (2019) 14 *Journal of Empirical Research on Human Research Ethics* 190.

³⁶ Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2* (Government of Canada 2018).

³⁷ National Ethics Advisory Committee (New Zealand), 'Cross-Sectoral Ethics Arrangements for Health and Disability Research: Discussion Document' (2014) <<https://neac.health.govt.nz/system/files/documents/publications/consultation-cross-sectoral-ethics-arrangements-health-disability-research.docx>> accessed 16 October 2019.

their position on an issue; power dynamics may arise between ‘expert’ and ‘lay’ members, not to mention between the REC Chair and the other members. The REC Manager and Scientific Officer themselves may play a crucial stewardship role that involves managing expectations and relationships across a network of actors. As a committee, RECs may be drawn further into power dynamics with their ‘managing’ regulatory authorities. As further chapters will demonstrate, hortatory guidelines and self-regulation have given way to legal regulation and centralized regulatory bodies to coordinate and manage RECs. RECs must navigate the complexities of modern health research and the challenging cross-cutting demands from their managing regulators that encourage both protection of research participant interests and also promotion of health research. This entails a *working through* of the interests of researchers and research participants, and of science and society as well—which suggests that the process of determining whether research is ethically acceptable is also a regulatory process.

The legal scholar William Curran observed many years ago that ‘[t]he use of review committees is a common law approach. These committees will be building the law as they go along.’³⁸ Curran’s comment was more aspiration than observation; nevertheless, the regulatory process is observed both in statutory regulations that RECs follow or apply to research proposals (e.g. research involving adults with incapacity), as well as in the regulatory techniques they employ to govern research. Indeed, as regulators themselves, RECs can look not only to what laws and regulations may (or may not) say about a proposal, they can also issue researchers many self-generated regulatory commands in their opinion letter, concerning, for example, whether a research design is flawed; whether a researcher may use human tissue; whether a participant has mental capacity to consent; whether different groups of participants should be included in the project; and not uncommonly, whether the information sheet says too little about burdens or risks or misrepresents what may happen in the project. Such commands, it seems, reflect a hybrid blend of legal and ethical reflection that *in toto* signify a pervasive power to render a regulatory judgement of ‘yes’, ‘maybe’, or ‘no’. In effect, the REC’s opinion is a regulatory event licence: without a positive opinion, research simply cannot proceed, either by way of law (in the case of clinical trials, for instance), policy, or practice (in most

³⁸ William Curran, ‘Governmental Regulation of the Use of Human Subjects in Medical Research: The Approach of Two Federal Agencies’ (1969) 98 *Daedalus* 542, 585.

other instances of health research, where it likely would not be published in any reputable journal).

Since the millennium, and especially as NHS RECs are now under the direct or indirect management of the HRA through the Care Act 2014, the role hierarchy of participant protection and research promotion has flattened. To some, this is concerning. Years ago, legal scholar Emma Cave and bioethicist Søren Holm expressed concern that the EU Clinical Trials Directive 2001/20/EC 'led to a subtle change of emphasis from the protection of research participants to the facilitation of research'.³⁹ In the same time period, Deryck Beyleveld, a legal scholar, expressed concern about a conflict of interest the dual roles could create:

The root of the problem is that, despite the World Medical Association Declaration of Helsinki, the management of the REC system believes that the role of RECs is not just to protect the rights of research subjects, but also to facilitate good quality research. [...] [T]his just highlights a conflict of interest. A dog cannot serve two masters, and the role of RECs, in fact, is solely to try to prevent unethical research. The facilitation of research is the role of other bodies.⁴⁰

It must be said that the ethical, political, and regulatory processes by which RECs render an opinion may well manifest quite differently under the research-transformative HRA compared to when these above statements were made in the early years of the millennium. The HRA's centralizing command may resolve some or most of the problems that critics (mainly health researchers) have levelled against RECs for years, but it may also lead to collateral, even unintended changes in how RECs review research proposals. If changes do emerge in this next-generation regulatory environment, it is an as-yet unknown answer what impact they may have on participants, researchers, and society. Phrased both empirically and normatively, can and should RECs both protect and promote? And if this is indeed how they operate, what model of health research regulation might be best suited to deliver these roles effectively?

A secondary question arises regarding the mechanism of working through protection and promotion. The roles may work together, but they are not necessarily balanced, nor might 'balance' be the appropriate mechanism. 'Balance' is ubiquitous in the legal and regulatory literature,

³⁹ Emma Cave and Søren Holm, 'New Governance Arrangements for Research Ethics Committees: Is Facilitating Research Achieved at the Cost of Participants' Interest' (2002) 28 *Journal of Medical Ethics* 318.

⁴⁰ Deryck Beyleveld, 'Law, Ethics and Research Ethics Committees' (2002) 21 *Medicine and Law* 57, 72–3.

alongside terms such as ‘reasonable’ and ‘public interest’, but can serve as a rhetorical ploy in regulation to mask lax reasoning or other mechanisms that might be in play to render judgement. Robert Veatch has observed that IRBs in the US may employ different techniques to interpret and apply the ‘fundamental’ biomedical ethics principles of respect for persons, beneficence, and justice. These include: (1) a ‘single principle view’, where one principle takes precedence over the others; (2) a ‘simultaneity view’, where all principles must be satisfied simultaneously for a research protocol to be deemed acceptable; (3) a ‘balancing view’, where the principles taken together must be satisfied on balance; and (4) a ‘ranking view’, where principles can be rank-ordered such that the highest ranking principle must be fully satisfied before the next rank is considered. Veatch further observes that regulation in the US fails to offer a theory of what should happen when a proposed research project involves a conflict of principles.⁴¹ In the subsequent chapters, I take up this important observation, arguing that it may apply equally to the objectives of protection and promotion, and that, in the absence of an expressed theory of how these two objectives should be achieved, a regulatory framework should be crafted to help actors in health research move through these critical questions in the research lifecycle.

If, as a secondary question, we investigate the rhetorical use of or under-theorized reference to ‘balance’, we may further wonder if RECs evaluate research proposals implicitly in stages and act as gatekeepers or stewards at several thresholds. For example, do they first assess a proposal to see if it satisfies a ‘tolerable (risk of) harm’ (i.e. participant protection) threshold, and if so, then move on to consider whether it satisfies a subsequent ‘social value’ or public benefit (i.e. research promotion) threshold? If so, what happens in these stages of dual commitment—of accommodating potential harms to participants as well as potential benefits to society, not to mention other considerations? In this realm of possibility, might a REC take a lead in maximizing outcomes such as suggesting ‘improvements’ to the research questions, methods, proposed uses of findings, and so on? If so, this would suggest less a concern with adjudicating ‘balance’ and more a concern with stewarding research optimization.

This question of balance versus optimization (or something else) regarding protection and promotion remains open. It also raises several

⁴¹ Robert Veatch, ‘Ranking, Balancing, or Simultaneity: Resolving Conflicts among the Belmont Principles’ in James Childress and others (eds), *Belmont Revisited: Ethical Principles for Research with Human Subjects* (Georgetown University Press 2005).

additional questions about the impact this next-generation regulatory environment may have on RECs—whether RECs encounter these potentially competing roles of protection and promotion in their work, and if so, how it is operationalized in their practices.

V. CONCLUSION

RECs have been a backbone in regulating the ethical acceptability of health research for half a century. They serve as gatekeepers that determine whether a proposed research project is ethically acceptable and therefore may proceed. RECs not only play a central role in health research regulation, they also hold tremendous power over what knowledge is produced, and from knowledge production across the translational divide, what medico-scientific innovations are created. While many support the underlying idea of *ex ante* ethics review by a committee as a means of protecting and promoting the rights, interests, and welfare of participants, many also have expressed dissatisfaction with the structure of the ethics review system and the individual processes of RECs. As later chapters will explain, multiple regulatory techniques and instruments have been employed over the years in the hopes of remedying the many problems attributed to RECs, foremost the concerns of inefficiency and ineffectiveness. Many researchers found the regulatory techniques and instruments of yore, particularly through the 1990s and in the form of ‘guidance’, to offer a weak remedy.

Recent changes may bode differently. Since its formation in late 2011, the HRA has been tasked with both protecting research participants from harm and facilitating a productive research environment by streamlining health research regulation. The HRA is a central regulatory body that is seen to help make the UK once again an attractive place to conduct health research such as clinical trials. Money, jobs, and international pharmaceutical and regulatory competition are all at stake. One pathway to make the country more attractive for conducting health research, and to provide national economic benefit, is to remove perceived regulatory thickets. Ethics review has been viewed as part of this thicket.

The HRA, particularly through its RES and equivalent bodies across the UK, are working to make REC processes more effective and efficient. As the HRA’s RES website states: ‘We have a duty to provide an efficient and robust ethics review service that maximises UK competitiveness for health research and maximises the return from investment in the UK,

while protecting participants and researchers.⁴² What is unclear, however, is how this stress on *duties* of efficiency and maximization of ‘UK competitiveness for health research’ and maximization of ‘return from investment in the UK’ may affect the substantive and procedural workings of RECs. Can or should efficiency, as well as competition and investment maximization, be accomplished while simultaneously protecting participants? The UK is seen by many as a leader in health research and its regulation, and many have taken an interest in the country’s recent reforms. As one author notes in a review of health research regulation across four countries:

The current regulatory complexity [across the globe] appear[s] to be largely irrational, probably arising from piecemeal reactions to specific problems and scandals in the past. Thus, the new [...] HRA is of great interest in terms of future developments. If successful, it may have an impact outside [the UK].⁴³

Empirical evidence is needed to investigate the questions posed in this chapter. Through document analysis, in-depth interviews, and observation—and guided by anthropological and regulatory theory—we should endeavour to build a knowledge base from which we can investigate the nature of health research regulation, pinpoint weaknesses, and recommend improvements—in other words, we should embark on an anthropology of regulation and build an evidence-based regulatory framework. There is a need for qualitative research, asking how and why RECs make the decisions they do, and how the nested dynamics of RECs and central ‘managing’ regulators play into decisions. By gaining a critical understanding of what RECs actually do and exploring the nature of health research regulation, such research could offer a crucial contribution to understanding the roles actors play in health research and how these roles transform over time and across stages in research.

The next chapter traces the regulatory development of RECs and health research regulation within the UK, with a view to demonstrating both the growth of health research regulation and the increasingly central role that RECs play in regulating health research. For many years, there were repeated calls for reform to how RECs were structured and operated, particularly from the research community—a community, of course, that

⁴² Health Research Authority, ‘Research Ethics Service and Research Ethics Committees’ <www.hra.nhs.uk/about-us/committees-and-services/res-and-recs/> accessed 16 October 2019.

⁴³ Elina Hemminki, ‘Research Ethics Committees in the Regulation of Clinical Research: Comparison of Finland to England, Canada, and the United States’ (2016) 14 *Health Research Policy and Systems* 5, 9.

always has participated in and been directly affected by RECs. The REC system in the UK has indeed recently undergone structural reform, partly due to ongoing macro-regulatory changes occurring at the EU level that impact Member States' national regulations. Overall, these reforms appear to have been to the satisfaction of the research community. What we will see is that, while to a certain degree, research promotion has always been embedded in the regulatory techniques of RECs, it has not until now been instantiated in law with the creation of the HRA and rules promulgated under the Care Act 2014. The subsequent and fundamental question to explore is whether this instantiation of research promotion in law has a (hitherto absent) trickle-down effect that impacts the day-to-day practices of RECs, and if so, how, or indeed, whether the law is only now coming to reflect an everyday practice that has long existed, or whether a more robust regulatory model—specifically a model built around regulatory stewardship—is needed to make sense of how protection and promotion are to work together.