

# Increasing recruitment to research studies via healthcare professionals: a systematic review

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Fewer than 50% of trials reach  
recruitment targets (Treweek 2010)

In palliative care this may be as low  
as 31% (Bennett 2009)

Can mean robust results are not  
achieved and intended benefits of  
research not realised. This has  
economic, time, ethical and clinical  
consequences (Ewing *et al.*, 2004; Barnes *et al.*,  
2005; McDonald *et al.*, 2006; White and Hardy, 2008)

# Reasons for poor recruitment?



Identification of possible participants is one step in a complex process

The Data Protection Act has created a barrier between researchers and participants

Healthcare professionals can become gatekeepers of potential participants

PRELIMINARY

1 Basic interpretative provisions

(1) In this Act unless the context otherwise requires—

data means information which—

# Reasons for poor recruitment?

Protection of vulnerable patients

Relationship with patients

Skills in introducing research studies

Equipoise and Workload

(Mason *et al.*, 2007; White and Hardy, 2008; Ives *et al.*, 2009; Department of Health, 2009)

BUT

Patients want to participate

Policy objective

(Hopkinson *et al.*, 2005, Shipman *et al.* 2008, Gysels *et al.* 2008, Terry *et al.* 2006, Department of Health 2010)



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Title:	Strategies to increase participant recruitment to research studies via healthcare professionals
Stage:	Registered Title
Last Updated:	27. January 2011
Entity:	Methodology Review Group (Reviews by this group)

# Review question

To identify and assess the effect of strategies designed to improve recruitment of participants to research studies via health care professionals

Search terms
1. patient selection.mp. or exp Patient Selection/
2. patient participation.mp. or Patient Participation/
3. incentives.mp. or Motivation/
4. "Health Services Needs and Demand"/ or "Salaries and Fringe Benefits"/ or Gift Giving/ or inducement.mp. or "Fees and Charges"/
5. Financing, Personal/ or Reimbursement, Incentive/ or pay\$.mp. or Cost-Benefit Analysis/
6. compensation.mp. or "Compensation and Redress"/
7. gatekeeping.mp. or Gatekeeping/
8. 1 or 2
9. 3 or 4 or 5 or 6 or 7
10. 8 and 9

CENTRAL, Medline, EMBASE, CINAHL, Psycinfo, ASSIA, British Nursing Index, Web of Science

The Ascent of Evidence  
(and the Evolution of Man)

W. H. W. H. W.



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fig. 1

fig. 2

fig. 3

fig. 4





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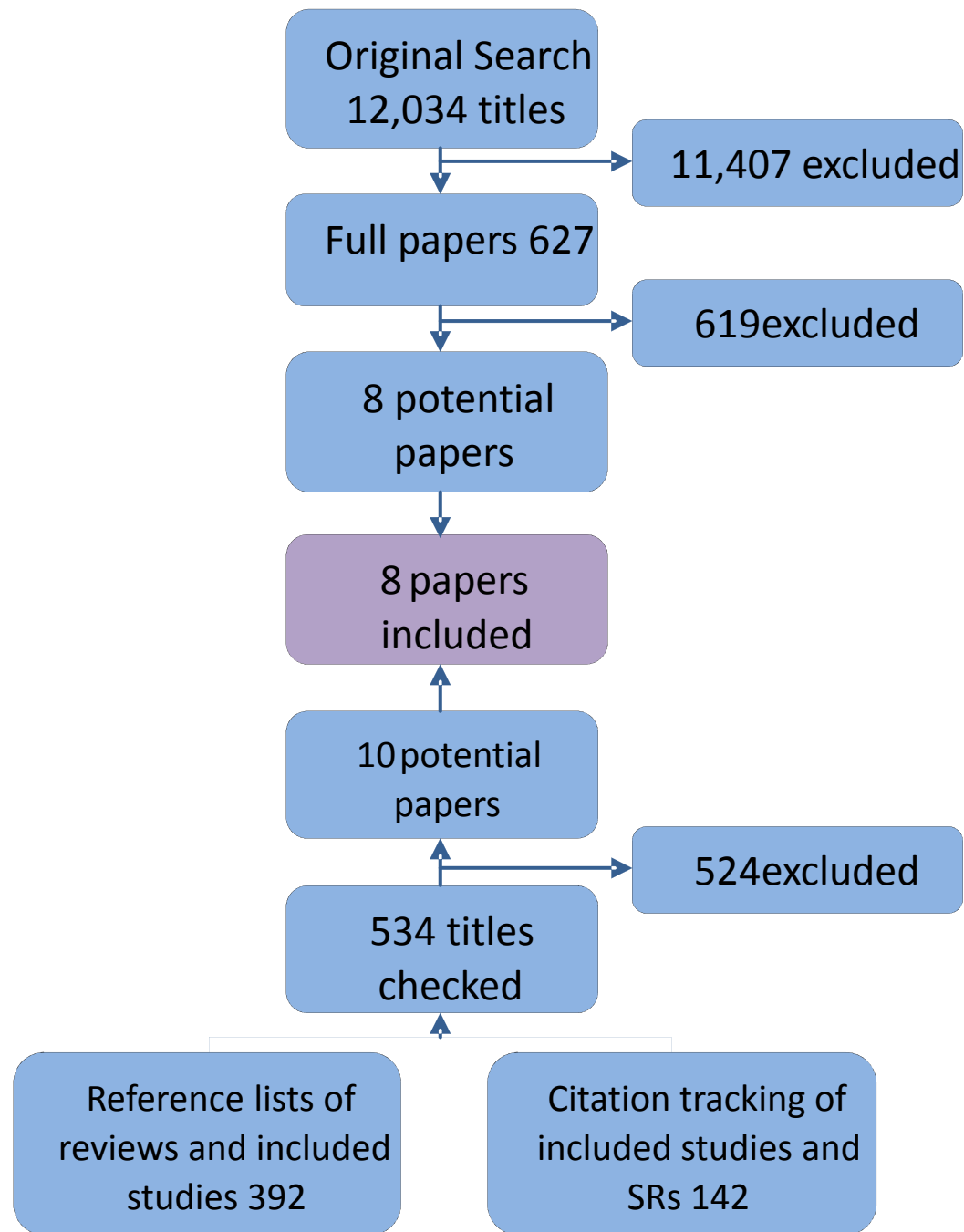
**Abstract checked - need full paper**

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<input type="checkbox"/>		2001	Recruitment of women to clinical trials. Lancet Added to Library: 02 Sep 2010 Last Updated: 02 Sep 2010 Online Link → <a href="#">Go to URL</a> 
<input type="checkbox"/>		2005	Increasing participation of cancer patents in randomised controlled trials: a systematic review. Added to Library: 08 Oct 2010 Last Updated: 08 Oct 2010 
<input type="checkbox"/>		2005	Systematic review of barriers, modifiers and benefits involved in participation in cancer clinical trials. CRD Report Added to Library: 02 Sep 2010 Last Updated: 02 Sep 2010 



# Strategy one: additional visits or information

Authors	Strategy	Study design	Result	Effect size
<b>Lienard 2006 France</b>	Onsite visits to recruitment centres	RCT comparing onsite visits with no additional visits	No statistical difference between groups in recruitment rates; early termination of trials; quality of data; or length of follow up	OR = 1.03  (95% CI: 0.52 to 2.02)
<b>Monaghan 2007 World wide</b>	Additional information	RCT comparing additional with usual information at 167 sites in 19 countries	No statistical difference between groups in recruitment rates or time to recruit a participant	Insufficient data to calculate OR – awaiting data from author
<b>Kimmick et al 2001 USA</b>	Multi-component educational intervention for staff	Cluster RCT comparing multi-component intervention with none across 53 institutions	No statistical difference between groups.  Intervention vs controls  (Yr 1: 36% vs 32%;  Yr 2: 31% vs 31%)	Yr 1: OR = 1.19  Yr 2: OR = 1.00
<b>Paskett 2002 USA</b>	Alerts from nurse and quarterly newsletters	Non-RCT comparing alerts & newsletters with none at 10 rural centres	No statistical difference between groups	No original data to calculate effect size.

## Strategy two: automated referral

Authors	Strategy	Study Design	Result	Effect size
<b>Nazemi 2001 USA</b>	Waiting room screening	Retrospective comparison of waiting room screening with physician referral	Waiting list less efficient (12.1% vs 22.8%) but identified more patients overall	OR = 0.47 (95% CI: 0.28 to 0.77)
<b>Bell-Syer 2000 UK</b>	Computerised referral list	Retrospective comparison of computerised referral with physician referral	Computerised method less efficient (8% vs 19%) but produced a high proportion of participants	OR = 0.36 (95% CI: 0.26 to 0.49)

## Strategy three: designated member of staff

Authors	Strategy	Study Design	Result	Effect size
<b>Cox 2005 UK</b>	Introduction of a clinical trials officer	Pre-post comparison	Recruitment rates increased (10% vs 14.6%) .	No original data to calculate effect size

## Strategy four: targeted recruitment

Authors	Strategy	Study Design	Result	Effect size
<b>Hollander 2004 USA</b>	Designated bays for recruitment instead of sharing bays	Pre-post comparison	No significant differences between methods (45.2% vs 44.0%)	OR = 1.03 (95% CI: 0.93 to 1.19)



Don't spend additional time planning site visits and giving additional information.

More research is needed to address the particular issues related to accessing and recruiting participants for palliative studies.

