Background

Given recent UK national policy directives encouraging a ‘

were conducted at work in private office rooms and lasted between 40 and 70 minutes. One of these interviews was conducted by telephone in a private office space and lasted 35 minutes. Interviews were conducted by one social scientist (MA), who took short notes at the interview, typed up longer notes immediately after the interview, and returned these notes to interviewees within 24 hours for corrections and additions before entering the anonymised transcripts into a password-protected research database. Notes were taken because the research was originally conducted as an initial mapping exercise of issues in the clinical research group. The interview schedule was limited to two core questions: i) what factors support the recruitment of patients into clinical research here and ii) what factors inhibit the recruitment of patients into clinical research here. The interview schedule was deliberately open to allow for interviewees own interpretation of factors. Probes were as neutral as possible, e.g. "can you tell me a little bit more about this?" "Can you give me an example?" One transcript was not returned and so was removed from the database; therefore, data were collected from 11 interviews. Returned transcripts were organized and coded by MA using qualitative data analysis software (NVivo9).

Following Ritchie, analysis of the data involved, first, a descriptive examination "unpacking the content and nature of a particular phenomenon or theme" [42] from the data set and, second, an explanatory account that involved "finding links and connections between two or more phenomena"

research could place on clinical teams. When recruiting patients from acute and emergency care, research teams often had to rely on non-research staff to identify potential research participants for particular studies. Non-research staff did not have protected or allocated time for recruiting patients and interviewees perceived that busy ward and outpatient staff easily forget about research work. Experienced research nurses sought to address this locally by relocating their offices or clinical rooms closer to

recruiting patients because staff were unsupportive of the study, particularly when faced with opposition from non-research clinical colleagues. The findings also suggest that staff perceived that schedules of return hospital visits, home monitoring requirements, lifestyle changes, or treatment regimens often created unexplained or unanticipated burdens of research participation that were too onerous for the elderly or the very sick. However, other staff noted

experience of at least some front-line staff is that these contributions are either insufficient (and so require a closer factoring into research design and funding applications) or that these contributions are not reaching the relevant clinical areas. In either case, the insufficient contribution to the research work conducted in wards and clinics leads to strain between clinical and clinical research work and resourcing priorities, with a deleterious impact on recruitment.

Maintaining the focus on previously overlooked high level factors, our findings highlight that some recruiters to research perceive that established ethical regulatory expectations – that prevent researchers from promising direct benefits to patients in research – are a barrier to being able to offer appropriate compensation and encouragement for patients offering time and clinical labour. These findings cannot provide any estimate of the prevalence of this view and, regardless, ethical standpoints are not a simple matter of democratic decision making. However, ethical standards are not static. As social constructs, they change over time. In this regard we suggest that the voices of those undertaking recruitment be heard as part of a wider critical review of the ethical requirement that patients should not receive direct benefit for participation in publically funded research.

Finally, the findings suggest that the established hierarchies of research work, with the lowly work of recruitment and retention undertaken by more junior professionals and, increasingly, non-professionals, operates as a barrier to successful work. Our interviewees noted the relative success of some senior research clinicians in recruiting patients into studies either because of their authority, knowledge of the study, or communication skills. More significant, the value of clinical research team leadership that included a whole team approach to patients in research was noted by our interviewees as an especially successful way of enhancing patient recruitment and retention.

Our study is limited in several respects. Our aim was not to examine all issues impacting recruitment. Instead, we sought to examine how staff who recruited patients understood and explained the barriers and opportunities

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