IRB ADVISOR

YOUR PRACTICAL GUIDE TO INSTITUTIONAL REVIEW BOARD MANAGEMENT

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IRBs Must Prepare for Studies Involving Transgender Populations

There are some unique vulnerability issues

More people in the United States are openly lesbian, gay, bisexual, or transgender (LGBT) than ever before. And the prevalence of people who identify as LGBT is close to five times greater among young people than among seniors.

"A Massachusetts behavioral risk survey for 2016 showed that 15.5% of people in the 18 to 24 age group had self-identified as homosexual, bisexual, or other; among the 65 and older group, 2.7% identified that way," says **Sean Cahill**, PhD, director of health policy research at the Fenway Institute, and affiliate associate clinical professor in the department of health sciences at Bouve College of Health Sciences, Northeastern University in Boston.

"Looking at data, the younger age cohorts are much more likely to self-identify as lesbian, gay, and bisexual than the older age cohorts, and I think we're seeing a similar phenomenon with transgender people," Cahill says.

"In our survey, 0.4% of adults identified as transgender in 2016," he adds. "Fully 2% of high school students identify as transgender, so there are many more young people who identify as transgender or gender nonbinary or gender nonconforming."

> TRANSGENDER PEOPLE ARE MORE AT RISK FOR STIGMATIZATION, VIOLENCE OR THREATS OF VIOLENCE, AND BULLYING — PHYSICAL, MENTAL, OR OTHERWISE.

Transgender people are more at risk for stigmatization and violence or threats of violence, or bullying — physical, mental, or otherwise, says **Beth E. Roxland**, JD, MBioethics, an independent senior consultant on law, ethics, and policy, and an associate

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AUTHOR: Melinda Young
MEDICAL WRITER: Gary Evans
EDITOR: Jill Drachenberg
EDITOR: Jesse Saffron
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

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EDITORIAL QUESTIONS
Questions or comments?
Call **Jill Drachenberg**,
(404) 262-5508.

in the division of medical ethics at NYU Langone Medical School in New York City. Both Cahill and Roxland discussed situational vulnerability and gender identity at the Advancing Ethical Research Conference in San Antonio, TX, by Public Responsibility in Medicine and Research (PRIM&R) Nov. 5-8, 2017.

Transgender people also are at greater risk than the general population for behavioral health issues, social victimization, abuse, poverty, suicide, HIV infection, unemployment, and homelessness, Cahill says.

"The National Transgender [Discrimination] Survey 2016 by the National Center for Transgender Equality surveyed 27,715 transgender people in the U.S. and found 46% reported verbal harassment in the past year," he says. "Nineteen percent reported being physically attacked in the past year, and there was three times the rate of unemployment when compared with the general population, and a 30% rate of lifetime homelessness."

Also, most transgender people say they experience discrimination. Those same people have twice the risk of adverse emotional and physical symptoms, including headaches, upset stomach, feeling sad, frustration, anxiety, and a pounding heart, Cahill says.

All of these factors mean that the transgender population has situational vulnerability that should be taken into account when IRBs review studies enrolling these individuals.

"If someone is going to do research with transgender people to benefit the transgender community and improve health outcomes, then it's important to know that transgender people experience a lot of health issues," Cahill says. "Some are related to discrimination and victimization in society."

Cahill and Roxland offer the following suggestions for ethical and other issues to consider when reviewing studies involving a transgender population:

• **Include input from someone knowledgeable about transgender people in the IRB review.** "Ideally, you might find a community member who can be involved with the review, or you could get someone with a parallel life experience involved," Roxland says.

Other populations with situational vulnerability, such as homeless people, experience similar issues, she notes.

The idea is for both IRBs and researchers to find people who can engage with the LGBT community, recruit, and help mitigate the risks of the research, including privacy and confidentiality risks, Roxland says.

Professional research groups, like the Fenway Institute, include experts who often are willing to speak with researchers and IRBs about the issues they see in LGBT populations, Cahill says.

• **Seek information about transgender and LGBT communities.** The Fenway Institute has a lot of information and materials on its website for healthcare providers, Cahill says. *(For more information, visit: http://bit.ly/293wV0w.)*

"We do a huge amount of training and technical assistance to provide firm and competent care to LGBT people, including on-demand webinars," he says.

It's important that researchers and IRBs learn more about these communities because of their

vulnerability and additional risks when participating in research, Cahill notes.

"I recommend that the research team has familiarity with the population, and it's not just the principal investigator," he says. "They should be encouraged to have some tools and resources on hand for the other researchers to also become familiar with it."

• Consider risk of harm with parental/guardian consent. "Usually minors can't give personal consent, but by requiring guardian consent in certain circumstances you may be exposing them to more stigmatization within their family," Roxland says. "So, with some studies that are no more than minimal risk, you can expose them to more harm by getting parental consent than if you waived it."

Whether to seek parental consent or a waiver of parental consent is an important risk and privacy consideration. Regulations give IRBs the authority to waive parental permission if the research protocol is designed with conditions or for a population where parental/guardian consent is not reasonable, Cahill explains.

"An appropriate mechanism for protecting the children is substituted," he says. "So, we argue that if we seek parental consent to interview the adolescent about same-sex attraction or behavior or identifying as gay or bisexual, then that could potentially out young people who are not out to their parents, and it could cause trouble for them at home."

Simply contacting a guardian could place a transgender youth at risk of abuse or being abandoned. Researchers could argue that obtaining parental consent would make it impossible for them to conduct the research study and understand that population, Cahill adds.

• Ensure privacy and confidentiality. Research involving transgender populations can expose study participants to harm should their identity be reported, so data security, privacy, and confidentiality safeguards are very important.

"Our national online survey is very anonymous, and we give people pseudonyms," Cahill says. "They are totally confidential and include no identifying information."

> "I RECOMMEND THAT THE RESEARCH TEAM HAS FAMILIARITY WITH THE POPULATION, AND IT'S NOT JUST THE PRINCIPAL INVESTIGATOR."

For in-person focus groups, investigators use a screener and all information is confidential, he adds.

"There is a risk someone will go to the in-person focus group and see someone they know," he adds.

And at the end of the focus group, researchers offer participants a referral to a suicide prevention-focused LGBT youth hotline?TY if they need help.

• Watch out for additional risks. Transgender individuals often have high levels of stress and sexually transmitted diseases, Roxland says.

Weight management, especially for transgender females, can be an issue, and there is greater risk of sexually transmitted diseases, she adds.

"A lot of time, when we're talking about youths, there could be more cutting school classes and acting out and avoiding the folks who stigmatize them," Roxland says.

Whether research could exacerbate these issues is a question for an IRB to consider.

"They might need additional support because of what they have to deal with, but they're not weak or at fault," she says.

• Consider including transgender individuals in single-gender studies. When researchers are conducting studies involving Pap smears, they might consider enrolling transgender men who were born female and now identify as men, but could still be at risk of cervical cancer, Cahill suggests.

Likewise, transgender individuals could be enrolled in prostate cancer research.

• Include transgender people in participatory research. "We have another research project where we're trying to understand health risk factors of LGBT youth of color, and we're using the community research participation approach," Cahill says. "We have a pilot intervention to reduce disparity, and we've identified depression and social anxiety as significant behavioral health issues."

The participatory action research works with the youths to see if strategies of mindfulness for stress reduction have any effect on their social anxiety and depression, he says.

"These youths have been incredibly involved in informing our research approach," Cahill says. "What's cool is that young transgender people and gay and bisexual men have been very involved in developing the project." ■

De-identifying Data in Qualitative Research Is Complex, Time-consuming

There are various ethical issues

One of the more complicated issues social, behavioral, and education research (SBER) investigators and IRBs might consider involves how to de-identify data for use in qualitative studies.

De-identifying data in a medical record for a clinical trial is very different from de-identifying data in a SBER study, says **Laura A. Henderson**, MA, senior IRB administrator of the committee on the use of human subjects at Harvard University in Cambridge, MA.

Removing identifiers in biomedical trial data requires a different set of considerations than removing identifiers in qualitative SBER research.

"Quantitative data can be much more readily de-identified and in a much cleaner way," Henderson says. "In quantitative research, you might have an Excel spreadsheet and have separate fields for names, addresses, ZIP codes, demographic variables, and those kinds of things."

Stripping data of those identifiers is simple. "Qualitative data is way different," Henderson says. "In my field of culture anthropology, you might look at extremely detailed field notes — life histories, for instance."

Investigators and IRBs must ask what de-identification looks like in this type of research. How do they take something that is, basically, defined by its context and richness of story and personal meaning, and de-identify it?

"In my field, if we're interviewing somebody, it's all about how their story is reflective of larger social realities," Henderson says.

This information can be useful in research studies beyond the original study, she notes.

"We want to use it to its greatest capacity," Henderson says. "People can examine what you've done and hold it up for peer review and take data and think about it in different ways and enrich common knowledge through new analysis."

Researchers could replicate a study, building on existing data. They could take one data set and have it informed by another person's data set.

"There's a growing interest in pushing people to share their data and enabling them to provide an infrastructure to share their data," Henderson says.

But this is where it becomes challenging. There are no easy answers to the dilemma of how to de-identify this type of information without rendering it useless.

"If you take out all of the stuff that can betray the identity of somebody, do you have anything left that can be used, or is it eviscerated of its core meaning?" Henderson asks. "Can you contribute something that actually has integrity and meaning if it's that deeply qualitative?"

For example, a researcher could exchange the person's home town with another town's name or say the person is an aesthetician in place of the person's job as a manicurist. These types of changes will mask the person's identity, she explains.

"But can it then be misunderstood because too much meaning has been stripped from it?" Henderson asks. "Could something be misconstrued because it has lost all of that context?"

For example, what if the person being studied lived in a town near a former nuclear test area and this person's childhood traumas were influenced by that regional context? Stripping the person of that place identity would change the way researchers might view the person's social-behavioral issues.

Another issue to consider is how the de-identification is described in the informed consent.

Sometimes investigators anticipate an IRB requiring data destruction and will add to the informed consent that all identifiers will be destroyed in one or two years, Henderson says.

"They box themselves in to do it," she says. "They don't think through the other ways they could collect data and organize it for use further down the road."

Also, the process of de-identification might conflict with what the study participant agreed to in the informed consent process.

"This might be a person who spent hours pouring their heart out about stuff deeply personal to them," Henderson says. "If they saw that the next step of representation is to share the data, and all those things are missing from it making it much more generic in nature, then that could be a problem in how it might not jibe with the spirit of the consent process."

IRBs will encounter this type of issue with long-term qualitative research, where the researcher is building up a relationship with informants over time, she says.

"That process of sharing information back to them and

checking back with them is growing in acceptance within the framework from an IRB perspective, as part of a continual informed consent process," she adds.

Sometimes, investigators might share with participants how their information has been changed. Henderson has seen this type of process described in protocols and sometimes intertwined with a research orientation that is informed by certain social theories.

"The best example of this is participatory action research," she says. "It cuts across disciplines, but people who use that approach tend to be more on the humanistic side: public health, anthropology, smaller groups of individuals."

Sharing research sometimes comes up when investigators want to return something of value to the community, as well as have an interest in speaking correctly on their behalf, Henderson says.

Also, some people who are interviewed for SBER studies have a personal interest in staying identified.

For example, Henderson's thesis project was about trafficking and bonded labor. She met with youths at a rehabilitation center, which also served as a political action camp. The young people rescued were given literacy training, food, and housing, and they were taught to view their experiences differently. Rather than think of themselves as victims with no control over their lives, they were taught to transform their own narratives and stories to fit into a larger human rights narrative, she says.

As such, the children of various ages wanted to use their real names. They had no parental supervision and they had universally been abused. "They were seeking the public eye," Henderson says.

The research took place in the 1990s in India, and Henderson received approval after a full board review.

For qualitative research and de-identification, the IRB's role will depend on the data's phase of use. If de-identification occurs for a secondary use, then the original IRB might no longer be involved, Henderson says.

"Investigators might take out certain identifiers before putting the data in a repository," she says. "De-identification is time-consuming and very difficult to accomplish." ■

Finding a Path to Informed Consent for the Addicted

Expanding science requires new tools for addicted, mentally ill

As an opioid epidemic ravages the country — killing a staggering 60,000 people by overdose last year[1] — a cutting-edge question on the frontier of neuroscience is: Can addiction be blocked in the brain? Even if it could, the question for IRBs will immediately be: Can an addict give informed consent?

To help answer these questions and inform this forward-thinking premise, researchers at Stanford University School of Medicine in California will use a recently awarded National Institutes of Health (NIH) grant as part of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) initiative. Led by principal investigator **Laura Roberts**, PhD, the team will work with IRB members, neuroethicists, and research subjects to develop informed consent tools for the addicted and the mentally ill.

The research questions include, "What are IRB members seeing in protocols that are coming to them?" says Roberts, a professor in the department of psychiatry and behavioral sciences at Stanford. "What are they worried about? How do they appreciate the different risks and the benefits? What concerns do they have about the technology? It's very exciting to try to put together all these different perspectives and try to paint a picture of ethical issues in highly innovative neuroscience."

As the science advances, questions of ethical research and informed consent arise in part because neurological interventions could theoretically alter concepts of identity and sense of self in research subjects. The NIH BRAIN initiative was started in 2013 to address such questions, and the following are some of the other research protocols recently receiving grants:

- Neurotics of deep brain stimulation (DBS) systems targeting neuropsychiatric and movement disorders. PI: Gabriel Lazaro-Munoz, PhD, Baylor Medicine, Houston.
- Ethics of patients and care partners perspectives on personality change in Parkinson's disease and

DBS. PI: Cynthia Kubu, PhD. Cleveland Clinic.

• Achieving ethical integration in the development of novel neurotechnologies. PI: Winston Chiong, MD, PhD, University of California, San Francisco.

• Ethical safeguards for exit and withdrawal from implanted neurotechnology research. PI: Lauren Sankary, JD, Cleveland Clinic.

Q&A

For her part, Roberts also will examine how those with addiction or mental illness as compared to a healthy control group decide whether to participate in neuroscience research studies. Roberts fielded questions from *IRB Advisor* about the research.

IRB Advisor: Can you tell us a little about your background that led to this research project?

Roberts: I've been doing evidence-based ethics research for many years now. A big focus has been considering the perspectives of the people who have to "live out" the research. That might be the participants, the investigators, and the institutional review boards charged with the oversight. I make sure to take into consideration the responsibilities and perspectives of the different stakeholders in the work. I have done studies of people involving HIV, cancer, and schizophrenia, looking at questions like, "Do people view mental illness as different than physical conditions when it comes to the research context and vulnerability?"

In addition, I'm looking at the research context when it comes to IRB members. Some of our work has studied how IRB members assess risk, and how that might compare with how a person with illness, or an investigator, views risk.

IRB Advisor: This recently grant-funded study will follow similar lines?

Roberts: This new project, especially the initial phase, is very faithful to that kind of approach. We are trying to look at highly innovative brain research — neuroscience that, in particular, relates to mental health and addiction conditions. We don't have separate federal regulations [for them], so people are often concerned about vulnerability and exploitation in the research context. In the initiation phase of this study, we are talking with IRB members, innovative neuroscientists, and ethicists. We are also talking with people living with either a mental disorder or an addiction, or people who are family members of those with these conditions. We are trying to get a full set of concerns, impressions, and observations about what is going on in highly innovative neuroscience research. Whether it's studying circuits on stem cells — that is what we are going to learn. What are investigators actually encountering from an ethical point of view when they are trying to develop this really forward-thinking science? That is the first phase.

> "OUR GOAL IS TO DEVELOP A MORE NUANCED METHOD OR APPROACH THAT SCIENTISTS COULD USE TO LOOK AT WHAT MOTIVATES A PERSON TO COME TO A RESEARCH PROJECT."

IRB Advisor: Where will it go from there?

Roberts: Based on that, we are going to do a fairly broad survey that will include people with mental illness and addiction, and healthy comparison subjects. We will look at their motivations for going into research, exploring sources of strength or vulnerabilities that would bring them to potentially signing up for highly innovative brain research. We are not going to actually develop the [consent] tool in this particular project, but our goal is to develop a more nuanced method or approach that scientists could use to look at what motivates a person to come to a research project. If they are just desperate, or they can't get access to healthcare any other way, or they are pressured into it, then this tool or this method that we hope to develop in the next [phase] of this project would help to understand that. I think from an IRB point of view it could be a wonderful safeguard to adopt to help evaluate the authenticity of the consent and the ethical suitability of the participation by the research subjects.

IRB Advisor: How will the research component specifically looking at IRBs be set up in this first phase?

Roberts: Right now, we are going to use semi-structured, confidential interviews just to create a deeper understanding of the kinds of ethical issues that are coming up. That will help build this big survey we are going to do. I have also been talking with the NIH about whether we could do a much broader survey — a written or web-based survey. We are going to start with the Stanford IRB.

At this stage, we are just using the information to develop the survey instruments, so we are keeping it kind of small but in a highly advanced setting.

I just did a big project with IRB members nationally that looked at whether genetic research for psychiatric conditions was viewed in a special or different way across the country. We just finished that and we are starting to write up the data. It has not yet been published. We did deep engagement of IRB members across the country for that particular project.

IRB Advisor: Addiction certainly is a timely topic. Will there be separate research and possibly tools developed for addiction?

Roberts: I have been working in the addiction space for about 20 years. I can tell you on theoretical grounds that I believe we are going to have to build tailored instruments for working with addiction, because part of the definition of having an addiction is some sense of loss of control. To have informed consent, you have to obviously have adequate information and dialogue, and then decisional capacity. Authentic volunteerism is really a challenge when people feel powerless [due to] an addiction. Also in some mental illness as well, the nature of the symptoms themselves render the person feeling powerless or helpless — unable to read their own internal state. Those are all really threats to volunteerism.

IRB Advisor: What kind of neurology research breakthroughs might be possible for these vulnerable groups?

Roberts: That is a lot of what we are going to learn, but [some examples include] the brain-computer interface, artificial intelligence, and simulations that represent decision-making in vulnerable people. [The research could involve] taking stem cells and growing neurons from a particular person in vitro, then creating circuits with those neurons. There are a lot of really interesting ethical questions that come up.

IRB Advisor: Do you think it might be possible to alter brain neurology in a way to blunt addiction?

Roberts: We hope so, by understanding the circuits that govern motivation, craving, and impulses. If we could do some kind of intervention on those circuits, then we may be able to diminish the power of the addiction. The ethical challenge then is preserving all of the dimensions that make an individual person who they are. We don't want to be changing people or changing humanity fundamentally, but we do want to address these conditions that render people less than themselves. There are a lot of challenges here. ■

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1. Centers for Disease Control and Prevention. O'Donnell JK, Halpin J, Mattson CL, et al. Deaths Involving Fentanyl, Fentanyl Analogs, and U-47700 — 10 States, July-December 2016. *MMWR*. ePub: 27 October 2017. Available at: http://bit.ly/2idBfPT. Accessed Nov. 6, 2017.

Informed Consent Conundrum: Making the Complex Concise

Common Rule changes raise some difficult questions

New language regarding informed consent in the revised Common Rule seems benign enough at first reading, but actually accomplishing the directives in a scientifically valid manner is a formidable undertaking.

"It is difficult to take complex information and write it in a concise and very understandable way," said **Christine Grady**, MSN, PhD, chief of bioethics at the National Institutes of Health (NIH) Clinical Center. "Easy reading is damn hard writing."

Grady recently gave a talk at the NIH on the challenges of informed consent, citing this new requirement in the revised Common Rule: "Informed consent must begin with a concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate, organized in a way that facilitates comprehension."

"So this is now a regulatory requirement," Grady said. "The interesting question — something that I have been thinking about quite a bit — what is key information? What is the key information that somebody needs to be able to decide whether they want to participate or not? Does it include purpose, risk, benefits, and alternatives? Maybe it

includes all of those things. If that is the case, how do you put that in the front and then what goes in the rest of the consent form?"

One approach would be to include an executive summary at the beginning of the consent form, she said.

"Other people have said, 'No, you don't repeat information. Whatever you put up front, you don't repeat later on. You just build on it,'" Grady said. "Also, making something concise and focused is something people have been trying to do in research studies, but I don't think we have actually nailed down what that looks like."

Reading Comprehension

Multiple studies have raised issues about the length and comprehension of consent forms currently used in human research.

"When studies have looked at consent forms, the reading level is high," she said. "Most of the analyses that have been done on consent forms come in at around the 11th grade or higher reading level. The average reading level in the U.S. is in the sixth to eighth [grade] range — it is not 11th, that's for sure."

Unlike clinical care in which the goal is to improve the patient's medical condition, the goal of research is to produce knowledge, she said.

"In research, our goal is not to benefit the patient — even though patients often benefit from research," Grady said. "The goal is to answer a research question. Therefore, sometimes we ask people to do things that are not necessarily in their own interests, but for the benefit of others."

That heightens the ethical stakes, in a manner of speaking, because human research must ensure informed consent to research that may not be of immediate benefit to the participant.

"There is a constant debate about what information should be disclosed," she said. "I say that recognizing that the Common Rule and the FDA regulations have a long list of things that need to be included in an informed consent document. There are lots of stories of people struggling with the degree of information or the degree of complexity of the information that they provide to participants."

> "WRITING CONSENT FORMS IS AN ART. THEY NEED TO BE READABLE, UNDERSTANDABLE, AND THEY NEED TO EXPLAIN THE STUDY TO THE TARGETED PARTICIPANTS."

In any case, the consent and any supplemental materials must be approved by an IRB, whose members may be tempted to add other information they feel is important.

"It is interesting and ironic in a certain way that the IRBs more often than not make consent forms more complicated," Grady said. "I did a study a few years ago that had 82 IRBs and we asked them not to change the consent form, or to change it as little as possible. Ninety-some-percent of the IRBs changed the consent form, all in the direction of being longer and more complicated. So, IRBs are part of this problem."

The upshot is that consent forms tend to get longer under increased contemplation, and one reason is that the document serves more than one purpose.

"Consent actually has other functions besides helping people understand what the study is about and making informed decisions," she said. "Consent also protects the institution and the sponsor. There is a balancing act. What goes in the consent form is documentation of what the person was basically informed about. So, you are balancing understandability with protection of the institution."

By the time all bases are covered, a consent document may have considerable heft.

"Consent forms are long, and have actually, over time, gotten longer," she said. "If you go through the consent forms that are available here, some of them are 25 to 30 pages. It's very rare to see a consent form that is two pages."

Despite the trend toward information overload, some studies have found that even long consent forms leave out required elements.

"You can see the challenge here is that you may be missing things, but it may also be too long and complex," she said. "How do you balance those two things when are writing a consent form?"

Showing slides of consent forms that varied in reading level and the detail of information given, Grady elaborated on this conundrum.

"The question is, are we making it more understandable for all, or are we sacrificing information that they may really want?" she said. "And here's the answer: We don't know. We don't have enough data to know whether or not a person who is deciding whether to participate in a study would make a different

decision if they read one [consent form] versus the other."

There also are a variety of approaches in the way the form itself is used in discussions with a potential research subject.

"Some people use it as a very detailed script, and they go over one section after another with the prospective participant," she said. "Some people hand it to participants and say, 'Read it and ask me questions.' There's a whole range of behaviors in between."

Another new part to the Common Rule states that "informed consent must present information in sufficient detail, but it must be organized and presented in a way that does not merely provide lists of isolated facts but, rather, facilitates understanding."

That certainly sounds rational in theory, but again, the devil appears in the details.

"I applaud the idea of this," she said. "I think the challenge is, how do we do it? That is the struggle. How do you balance sufficient detail with understanding?"

One could presumably begin by dropping the laundry list approach, which may present a long scroll of information with little explanation or context.

"The one that drives me crazy is list of possible side effects," she said. "One will say diarrhea, and the next one down will say constipation. How do you have any idea of what this drug is going to do, other than mess up your stomach in some way?"

Grady concluded with the following tips for creating an easy-to-read informed consent document:

- familiar, consistent words, active verbs, and personal pronouns;
- short, simple, and direct sentences with limited line length;
- short paragraphs, with one idea per paragraph;
- clear and logically sequenced ideas;
- highlight important points;
- avoid acronyms and abbreviations.

"All of this needs to be reviewed and approved by an IRB," she said. "Writing consent forms is an art. They need to be readable, understandable, and they need to explain the study to the targeted participants. There are a lot of reasons to be careful about the length, the format, the reading level, and the complexity of the information." ■

PRIM&R Finds Itself Caught in State Travel Ban Controversy

California banned travel to Texas

Organizations like Public Responsibility in Medicine & Research (PRIM&R) schedule national conferences up to five years in advance. These sessions take time to organize and book space. They look for cities that can handle thousands of guests and offer some interesting attractions. Geographical fairness — so no one region is forever left out — also is a consideration.

But what they haven't had to worry about as much, until recently, is what the destination state's legislature is doing.

The 2017 PRIM&R conference was scheduled for November in San Antonio, TX. All was well until the Texas legislature passed legislation in May 2017 that allows adoption providers to turn away potential parents, including lesbian, gay, bisexual, and transgender (LGBT) families and others, based on the adoption providers' religious beliefs.

"There are some people we just know because we've been in touch with some constituents, who are choosing not to come to Texas out of their conscience," says **Elisa Hurley**, PhD, executive director of PRIM&R in Boston. Hurley spoke about the controversy a week before the conference.

Hurley wrote a letter to PRIM&R attendees, explaining how PRIM&R is nondiscriminatory and decided to continue to hold the conference in Texas, mostly because of the logistics involving the difficulty in finding another venue at short notice.

The Texas adoption bill and its potential for discrimination prompted the state of California to issue a travel ban against Texas, which meant researchers and IRB staff and members from the state's public universities were unable to attend the PRIM&R conference.

"The biggest impact is on the Cal State and University of California university systems," Hurley says. "Many have research programs, and those affiliated with state universities are probably the largest contingent of ours."

This type of controversy is relatively new, from PRIM&R's perspective.

"We've always generally kept an eye on issues around human rights and discrimination when picking conference sites," Hurley says. "It's been in the background."

But, starting in recent years, PRIM&R has paid closer attention to state legislation that can result in discrimination.

"What prompted us to keep a closer eye on what's happening legislatively around LGBTQ issues was the bathroom bill that passed in North Carolina," she says.

"The bathroom bill passed at a time when a sister organization was having meetings there, and the federal government would not sponsor federal employees to go to North Carolina," Hurley recalls. "So, we watched what was happening there with meetings and realized this might be happening more in the future, and we would need to keep an eye on what's happening legislatively that might be antithetical to our principles and those of our constituents."

When the Texas legislature was considering the adoption bill, PRIM&R stayed in touch with the city of San Antonio and its visitor's bureau. Both were lobbying state legislators to not pass the legislation, Hurley says.

"Then, in the spring, the adoption legislation had gone through, and that prompted California to add Texas to a list of states it was banning state-sponsored travel to," she says.

"To summarize, our awareness and our desire to keep our eye on these sorts of things really came to the forefront after what happened in North Carolina," she explains. "We looked at what was on legislation in states where we book meetings."

The PRIM&R board discussed the organization's options after the Texas bill passed and investigated options for moving the meeting. The organization decided to keep it in San Antonio, but to make it clear that Texas' actions did not reflect the organization's core values.

"It was a difficult decision to remain in San Antonio and it was not made lightly, but after a lot of consideration and weighing what would be the cost for our constituency to change locations at that late date," Hurley says.

"For what it is worth, we received almost unanimous positive feedback on the statement that went out to our PRIM&R constituents," she adds.

Also, PRIM&R has enhanced its online conference options so California researchers and IRBs can attend some sessions virtually.

"Our virtual meeting is much larger than it has ever been," Hurley says. "We're live-streaming the event."

The idea is to make PRIM&R accessible to as many people as possible, even if they cannot attend in person. Moving forward, PRIM&R will investigate potential locations, looking for places that are supportive of the organization's values, but this will be very challenging, Hurley notes.

"One thing that makes it challenging is that San Antonio fought as hard as anybody against this legislation in Texas," she says. "You can have very progressive municipalities that fit in more conservative states."

Also, assessing a state's legislative action is only one challenging factor in selecting meeting sites. PRIM&R still must find locations that are attractive to its constituents and can support a large conference. Also, there should be some geographical fairness so people in some states do not always have to travel across the country to attend.

"Selecting meeting locations for all organizations is probably going to be a little more involved and fraught going forward, given the current state of things," Hurley says. ■

Are Organ Transplant Recipients in a Trial Protocol Considered Research Subjects?

A complex issue that is key to greater organ availability

Given the high demand for organ donation, there arises a critical point when the donor is dead but the organs are still viable for transplant. Research protocols to extend this viability period are of great interest, but does that mean organ recipients must give informed consent as research subjects? Here we enter an ethical impasse, that if adequately resolved could increase the supply of organs for transplant.

Some argue that a concept of "clinical consent" would be appropriate given the pressures and

difficulties already attendant in an organ recipient. The idea is that a population at considerable risk from a variety of conditions that go with needing an organ donation could give clinical consent to receive an organ from someone in a research protocol if it became available.

"Recipients have to process all of these things, but in our view, prior research on an organ can easily fit within that existing framework [of risk]," says **Kate Gallin Heffernan**, JD, a partner in the Verrill Dana law firm in New York City. "In bolstering that as a piece of the clinical conversation, you are not just leaving people with no information. You are actually finding a better way to give the information that is pertinent to their decision. In some ways, this could reduce the ethical conundrum because you are not asking them about research participation in the moment when they are deciding, 'Do I take an organ which may or may not be my last chance to get one?'"

Heffernan co-authored a paper on the subject, noting that "interventional research on deceased organ donors and donor organs prior to transplant holds the promise of reducing the number of patients who die waiting for an organ."[1]

However, currently "the perception that the existing regulatory barriers are insurmountable has all but shut down clinical research that is necessary to expand the pool of available organs," she concluded in the paper.

"This is primarily a logistics and timing issue," Heffernan tells *IRB Advisor*. "Given the way our organ allocation system works, you don't know until the offer is made and accepted where an organ will go. Until the allocation occurs, you don't know who your research subject is — if you are going to assume that the [organ recipient] is a research subject. So, in terms of being able to get IRB approval ahead of time for every single transplant at any number of centers it may go to is almost logistically impossible."

Though the issue was already subject to some difficulties, a high-profile complaint that likely created a chilling effect was filed by the public watchdog group Public Citizen.

The group argued that kidney recipients from a hypothermia study were, in fact, research subjects and should have been asked to grant informed consent.[2,3] The Office of Research Oversight at Veterans Affairs essentially agreed with Public Citizen, though Heffernan argues in her paper that they erred in doing so. The IRB, in fact, deemed that the study posed minimal risks to the organ recipients and that informed consent was not needed, she notes.

"The whole purpose of the work that is being done by transplant researchers in this area is with the hope of finding ways to better improve transplantation and the viability of organs post-transplant," she says.

Heffernan says the situation warrants creation of a national centralized review board that could provide critical oversight of interventional organ donor research. Centralized review would allow for the creation of reliance arrangements between medical centers that could facilitate IRB review and address any ethical issues before the critical moment when the organ becomes available for transplant.

"This would be a way to sort of front-load some of the evaluation of the research ethically so that you aren't faced with the real-time moment where it can't go forward because you can can't get the [local] IRB to review it in a timely manner," she says. "Some studies will require an IRB-level oversight for the recipients. Others may not. They would just need to have the ethics review that we all agree should be in place." ■

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COMING IN FUTURE MONTHS

- IRB leaders offer direction for SBER changes under new Common Rule
- Issues to consider when research could involve pregnant women
- Best practices in handling potentially exempt studies
- How are IRBs dealing with new tracking device protocols?

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CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. **In a Massachusetts behavioral risk survey in 2016, 2.7% of people ages 65 and older identified as homosexual, bisexual, or other. What percentage of youth, ages 18 to 24, identified that way?**

   a. 15.5%
   b. 11.2%
   c. 6.9%
   d. 5.4%

2. **Which is a reason for why it is more difficult to de-identify qualitative research data than quantitative research data?**

   a. Qualitative data include more detailed place descriptions.
   b. Quantitative data are more easily drawn from an Excel spreadsheet.
   c. Qualitative data contain information that can be misunderstood or stripped of meaning if all identifiers are removed.
   d. None of the above

3. **Christine Grady, MSN, PhD, recommended use of which of the following for writing informed consent forms?**

   a. Short, simple, and direct sentences
   b. Clear and logically sequenced ideas
   c. Avoid acronyms and abbreviations
   d. All of the above

4. **Kate Gallin Heffernan, JD, said transplant recipients could give which of the following to resolve the issue of receiving an organ that was under a research protocol?**

   a. Informed consent
   b. Clinical consent
   c. Waiver of future liability
   d. Limited acceptance

CME/CE OBJECTIVES

The CME/CE objectives for IRB Advisor are to help physicians and nurses be able to:

1. establish clinical trial programs using accepted ethical principles for human subject protection;
2. apply the mandated regulatory safeguards for patient recruitment, follow-up and reporting of findings for human subject research;
3. comply with the necessary educational requirements regarding informed consent and human subject research.