IRB ADVISOR

Your Practical Guide To Institutional Review Board Management

AHC Media LLC

IN THIS ISSUE

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Navigators: Liaisons guide families through informed consent

But must overcome perception they are IRB 'spies'

When a family is adrift on the unfamiliar waters of pediatric research, it helps to have a guide and translator. That's the forward thinking behind a program at Seattle Children's Hospital, which assigns two staff members to help bridge the informed consent process between investigators and parents fretfully considering research for their children.

The research and family liaison (RFL) program was introduced because of concerns that families needed support as they tried to get through the informed consent documents and conferences. RFLs work to meet this need, both by assisting families directly and by educating investigators about how to better communicate the fundamentals of informed consent to parents.

"We thought, was there a role that could help make the informed consent process do what it's intended to do, which is to inform the families about what research participation looks like?" says **Halle Showalter Salas**, MPhil, one of the RFLs currently serving at Seattle Children's Hospital. "There really was no role that sort of looks at the process. With IRB review, there's a lot of focus on the front end, but not a lot that happens after studies are approved in terms of looking at the informed consent process."

The RFLs attend all IRB meetings and have occasionally been asked by the IRB to help an investigator with informed consent issues. However, decision was made from the outset not to have the RFLs report directly to the IRB, emphasizes **Douglas S. Diekema**, MD, MPG, chairman of the hospital's IRB.

"I like the fact that the RFLs have a relationship with the IRB, but it's not necessarily a reporting relationship," he says. "The problem is that people do really see the IRB as serving a regulatory and police function, so anything directly associated with the IRB will unfortunately be perceived as, 'They're spying on us, they're watching us.' We didn't want [investigators] thinking the RFL was there to check up on them. They are there to assist them."

A touch of humanity

While the RFLs have spent time studying the research process and human subjects protection principles, they do not actually have clinical experience. A problem or benefit? As Diekema sees it, the latter.

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Editorial Questions

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"I think it's much more valuable to have somebody with a social science background than a science background," he says. "The problem with people with science backgrounds is that they already understand and speak a language that's a little above most people. Somebody with a background in the humanities or the social sciences is going to more readily pick up when science jargon is being used, helping [identify] when people might not understand what's being said."

The RFLs began by sitting in on dozens of informed consent conferences, not to assist families at first, but to get an understanding of how conferences worked and where they could be improved. Salas says they now attend some conferences to assist families. Because workload constraints make it impossible to attend all the conferences, they try to focus on higher-risk, more complex studies that may be more challenging for families to understand. One RFL is fluent in Spanish, making her an invaluable resource for Spanish-speaking families and for investigators who want to recruit them, Diekema says.

Lost in translation

In that regard, the RFL involvement with the Spanish-speaking parents has revealed that there were unreported difficulties in this area. In short, some things may have literally been lost in translation.

The families never shared that with anybody, because in order to share it they'd have to share it through the interpreter," he says, adding that the RFL has taken on the project of strengthening the hospital's overall interpreter services.

In addition to one-on-one meetings with families, the RFLs also work directly with investigators, sometimes at the urging of the IRB, if a protocol has been sent back because of informed consent issues. They conduct training for investigators to help them improve their informed consent documents and presentations. And they attend all IRB meetings to provide their perspective there, as well.

"We really try to bring up issues with assent and consent and parental permission, and to let them know what we have been seeing and what we're concerned about in this area," Salas says.

Both Salas and Diekema believe the presence of the RFLs has been helpful for IRB members. "They've helped the IRB be more sensitive to issues around recruitment and consent and how some-

thing might be perceived by a family," Diekema says.

An important factor in the success of the program has been institutional support, particularly because RFLs don't generate any additional income that would offset the costs of the program.

"I'm convinced to make this kind of thing work you need a very powerful champion," he says. "In our case, it was the president for research, who really felt passionate about the need for a role like this. Without that kind of person to block opposition, it's really difficult to get a program like this off the ground. Investigators inevitably will perceive it as one more barrier, one more hassle and they simply won't call — they won't use it. You do really need a champion who will say, 'You don't have a choice here. This is a program we're going to implement.' Once you do that, everybody sees there's some value added." ■

Parents of ill babies make tough choices

Informed decisions amid immense stress

The stress of dealing with a critically ill newborn did not prevent parents from making informed decisions about enrolling their child in research, according to a study conducted using a common competence assessment tool.

The findings counter previous studies that had raised concerns about the ability of parents to make informed decisions under such difficulty and time pressure.[1]

This study also marks a novel use of the MacArthur competence assessment tool for clinical research (MacCAT-CR), which is more commonly used to assess the competence of prospective participants with Alzheimer's disease, schizophrenia and other medical conditions that affect decision-making capacity.

"I think ours is the first study to use it looking at parents in a stressful situation," says **Sarah Hoehn**, MD, a pediatric critical care physician at St. Christopher's Hospital for Children in Philadelphia and a co-author of the study. "Our hope is that this is a tool people could use a lot more often moving forward — in terms of looking at the validity of informed consent."

Newborns in cardiac studies

The 35 parents assessed all had children who were undergoing open-heart surgery for critical congenital heart problems. All had made a decision in the 10 days prior to their assessment either for or against their child's participation in at least one of three studies:

- A study looking at the genetic origins of congenital heart disease, which required DNA analysis of a blood sample from the baby and blood samples and echocardiograms and/or electrocardiograms from the parents.
- A heart rate variability study, which required a continuous 24-hour electrocardiogram recording of the baby at three different points — before surgery, before discharge and at three months — in addition to medical and laboratory chart reviews.
- An MRI study looking for structural brain abnormalities and also investigating how inhaled carbon dioxide affected cerebral blood flow. This study was described as the most complex of the three.

The MacCAT-CR uses details from a study's informed consent document to assess four components of decision-making: Understanding of the study; appreciation of the voluntariness of participation and of the difference between research and clinical care; reasoning ability; and the ability to make a choice. Scores are assessed for each component and also totaled.

Hoehn says the hypothesis was that parents of critically ill newborns would score similarly with healthy adults who did not face similar stress.

"It was based on my prior experience with parents in this particular situation," Hoehn says. "Certainly from their perspective, they feel as though they are able to make good decisions. They might not understand the intricacies of every single part of a study or part of a procedure but they certainly feel as though they understand the risks and benefits and that they're making an informed decision for their children, whether it's for surgery or for a research study."

And in fact, the overall scores for the parents were generally comparable to those of adult control groups in previous studies using the MacCAT-CR, with a few exceptions.

This appears to run contrary to previous studies that had found 70% of parents having difficulty with at least one of the criteria for consent, such as competence, information, understanding or choice.

Another recent study reported that 12% of parents who made decisions about participation in a trial didn't recall 18 months later making that decision.

Hoehn says she thinks the results from this study were different because her group spoke to parents within 10 days after the decision, while other studies didn't talk to parents until months afterward.

"I think that's one of the strengths of our study," she says. "I think if you ask people what they remember 18 months later, you're not going to get a very good recollection."

The challenge of complexity

Of the three studies parents were asked about, the MRI study had the lowest mean scores, including in the area of understanding. Hoehn and co-author **Aruna Nathan**, MD, an anesthesiologist at The Children's Hospital of Philadelphia, attribute that to the complexity of the MRI study.

"They all understood that their child was getting an MRI and getting something inhaled, but in terms of what the specific effects of the inhaled carbon dioxide were and what effect it could have on the brain, I think they didn't necessarily understand it to the level of detail that we were asking the question," Hoehn says.

Nathan says that in her clinical experience with parents, they often see a gain to having their child undergo an MRI, since brain abnormalities are associated with this population of newborns.

"So I think even if they probably didn't fully understand the risks — it is a very complex study — they did perceive a certain gain to participation," Nathan says.

Despite these scores, Hoehn says it's still important for IRBs to ask rigorous questions about studies that involve informed consent from parents under great stress.

"They need to really query the investigators to be sure that the parents understand," she says. "And I certainly think whether people use the MacArthur or some other tool — maybe asking parents to repeat certain parts back to them — the onus is on investigators to make sure that parents understand what they're signing their sick newborn up for, especially for greater than minimal risk studies."

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Conferences: Overcoming a failure to communicate

'Informed consent is not just a document, it's a process.'

The quote above is a familiar truism of human subjects protection. Nevertheless, many institutions still spend a lot of time grappling with the documentation of informed consent and precious little looking at how well the process of informed consent actually informs and prepares subjects for making a decision about research participation.

A Seattle team decided to look more closely at this problem, sitting in on dozens of informed consent conferences between investigators and parents who were considering enrolling their children in studies.[1] They looked at how well those conferences informed parents about fundamental human subjects protection issues — voluntariness, risks and benefits, the difference between research and treatment.

Mary Beth Foglia, RN, PhD, MA, an ethicist at the National Center for Ethics in Health Care of the U.S. Department of Veterans Affairs in Seattle, says the goal was to adapt quality improvement (QI) principles to informed consent practices.

"QI is an integral part of health care operations and should be for research, too," she says. "This study offers one approach to identifying and addressing ethics quality gaps in research activities."

Critical gaps uncovered

The 33 informed consent conferences included in the study all were conducted at Seattle Children's Hospital in 2006. They involved a range of studies, involving some children with life-threatening diseases and others with chronic medical conditions that were not life-threatening.

Each conference was observed by a research and family liaison (RFL) from Seattle Children's Hospital. The hospital developed the role of RFLs to help families navigate the informed consent process. (**See related story, p. 49.**) The RFL development team also created a consent conference observation tool (CCOT) that allowed RFLs to rate each conference based on the degree to which the presenter verbally explained the necessary information for informed consent to the family.

The results showed that nearly all of the conferences included an explanation of the voluntary nature of participating in a study and the differ-

ence between research and treatment. But other elements were not as consistently explained in conferences:

- In more than a third of the conferences, RFLs believed the risks and potential discomfort associated with the research were not explained to families;
- In two-thirds of the conferences, the presenter did not explain steps that would be taken to protect confidentiality in the studies;
- More than 80% of the time, presenters did not provide an explanation of whether and how families would receive research results, who to contact with questions, what payment or incentive might be given or potential costs or expenses to families.

The RFL observers also assessed the communications skills of the presenters. Presenters overall got good marks for helping parents feel at ease, trying to use understandable language and encouraging families to take the time they needed to make a decision.

But the RFLs believed that most of the presenters did not assess parents' understanding of the information, either through asking them questions or a teach-back method of some kind.

Changing the environment

In addition, the RFLs' field notes raised issues about the environment in which the conferences were held. Often, they noted, conferences were held in patient rooms, sometimes with the other occupant (and the occupant's visitors) present, which potentially exposed personal information to others.

Presenters and families were frequently interrupted during the conferences — either for caregiving activities for a patient or when the presenter or child's physician was paged. And families often were asked to enroll in a study while they were still processing the news about a life-threatening diagnosis.

"There is some evidence that the timing of the discussion can affect understanding — and understanding is the job of the researcher to ensure, from an ethics point of view," Foglia says.

In cases where time is of the essence, there may be methods researchers can use to revisit the decision in 24 or 48 hours, she adds. Taken with other improvements, such as teach-back or moving the conference to a more private place, this might address some of the issues raised in the study, Foglia says.

Investigators have shown interest in the results from this study so RFLs have included it in their education programs aimed at helping researchers better communicate with families, notes **Halle Showalter Salas**, MPhil, one of the two RFLs at Seattle Children's Hospital who conducted the assessments.

"We had the oncology group [at the hospital] ask us to come to their meetings and review what we were learning as this went on," Salas says. "They were very interested to hear what we were finding with their group. The fact that they invited us gives you some idea that they did see value in what was being discovered."

She says the RFLs also presented the information to the hospital's IRB as part of a larger effort to raise IRB members' awareness of informed consent issues.

Research programs should look at developing internal quality improvement programs to continually assess and improve in the area of ethics practices, Foglia adds.

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Voice of patients missing in adverse event reporting

Patient reports could unearth problems sooner

Rather than blind, call it a "deaf spot." The adverse event reporting from clinical trials that helps inform conclusions about a drug's safety has a crucial hole in it — the voices of actual patients taking the drug.

That's the opinion of oncologist **Ethan Basch**, who says reports from patients tend to be more sensitive to adverse events than those filtered through clinicians. Indeed, such reports could bring serious problems with a drug to light earlier.

"It's important that clinical investigators and IRBs or [data safety monitoring boards] have a real understanding of the toxicities of agents that we're evaluating," says Basch, MD, a researcher at Memorial Sloan-Kettering Cancer Center in New York City. "As such, anything we can do to improve our understanding of the toxicity profiles

of drugs or devices is beneficial. Because after all, what we're interested in is efficacy and safety."

Basch published his views in a recent commentary in *The New England Journal of Medicine*.[1] He says studies have demonstrated that compared to patients, clinicians tend to report lower severity of adverse symptoms from the same events.

Adding patient reports to the adverse events collected and studied in a trial could increase researchers' ability to pinpoint serious adverse events sooner, Basch says.

"As far as detecting symptoms, patient self-reporting is emerging as a gold standard," he says. "It's already the gold standard for efficacy evaluation and it should be the gold standard with risk evaluation as well."

Why do patient and clinician reports differ? Basch thinks it could be a combination of factors. In order for an adverse event to be reported, the patient must volunteer the information or be asked about it. Then, the clinician has to document it and a data manager has to classify the information using a system such as the Common Terminology Criteria for Adverse Events (CTCAE), and put it in a database.

Along the way, information can be lost or altered, affecting the accuracy of the data, Basch says "It's like the children's game of 'telephone' — you start with a word and by the time it gets to the end of the chain, it's something else — related, but different," he says. "That's what happens with the reporting of adverse events. Things get dropped or they get changed. Patients may downplay or up-play their symptoms to clinicians. The clinician may think the patient is exaggerating or downplaying and may alter what the patient is saying. And if we look from clinician to clinician, we're very unreliable, compared to each other."

Surveys by paper, phone

Basch says patient reporting could be accomplished in a number of ways — through human interviews, paper surveys or electronic means such as automated phone surveys.

"Automated telephone systems are the way that we book our airline ticket or our movie ticket," Basch says. "These kinds of systems are increasingly used for administering different kinds of efficacy measures. And these could also be used for adverse event reporting."

In Basch's view, those reports wouldn't go straight to an IRB or data safety monitoring board. Instead a report would go to the investigator, with severe symptoms triggering an alert to the research team, which could evaluate them to see if they require expedited reporting. Patient reports would ultimately be submitted with all other adverse events data at the conclusion of a trial.

The research community already is coping with a large body of adverse event reports, which some say create so much "noise" that it's hard to make out the "signal" of a real problem with a drug. While adding the patient reports could pose some administrative challenges, Basch doesn't think it would increase that noise-to-signal difficulty. For one thing, he says, we'd get a better handle on the baseline symptoms that patients experience, many of which may not have anything to do with the study intervention.

"It's possible that clinician reporting of adverse events is more specific but less sensitive and patient reporting is more sensitive but less specific," Basch says. "However, when it comes to detecting adverse events, we would rather be sensitive. We would rather not miss important things. What happens with clinician reporting is that we miss important things."

No IRB requirements

Still, Basch doesn't suggest that IRBs start requiring patient reporting in protocols they review. He says it's likely that investigators and sponsors will undertake it on their own, recognizing that it improves the quality of data being collected. Eventually, he says, he would like to see regulatory action, for example in the form of an FDA guidance.

Basch and his colleagues already have developed a Patient-Reported Outcomes version of the CTCAE (called the PRO-CTCAE) for the National Cancer Institute, as part of an initiative to introduce patient-reported outcomes in NCI-sponsored trials.

"I think IRBs do have a role, but first, I think this is going to come from investigators and regulators and then IRBs will follow suit," he says."I don't know that it's for IRBs to go back to investigators and say `You have to include a screen of patients for adverse events.' That said, when there are adverse symptoms of particular concern, it is warranted for investigators or sponsors to include patient-reported measures for those particular symptoms."

If an investigator proposes using a patient-reported tool in a trial, the IRB should ensure that

it is valid and reliable, and that the way it's being administered is reasonable, Basch says. There should be a mechanism for real-time review, with a clinician evaluating reports to see if something turns out to be a serious adverse event that requires expedited reporting, he says.

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Simplifying forms can save staff time, improve quality

Collect solid details; reduce questions

One issue regarding IRB submission compliance that often is overlooked has to do with the complexity of IRB forms. What if an IRB could make significant improvements in research site protocol compliance simply by simplifying and improving submission and other forms?

That is the theory behind the work one institution put into a quality improvement project involving its electronic forms.

And the changes have had positive anecdotal results: "The feedback has been outstandingly good," says **Joann Margaret Glacken**, MA, research support services specialist at the University of Illinois College of Medicine in Rockford, IL.

"People have said they like the new forms," Glacken adds. "The forms are longer, but they're easier to read because there's more white space."

The style is simpler, and the language used makes more sense intuitively. Some novice investigators have told Glacken that they now understand the forms for the very first time.

Glacken, who performs pre-submission reviews on each IRB application, expects the revised forms ultimately will help reduce IRB staff time in handling protocols.

"Using the new forms is helping reduce my frustration level," she says.

"This is something people don't talk about, but I believe wholeheartedly that people need to address in academia how to reduce both our man hours in the IRB office and our frustration with the workload," Glacken explains.

For example, Glacken found as she looked at IRB submissions that investigators and students conducting research stumbled over the same questions on each application. This suggested the problem was in the form itself.

"You can spend literally hours on a form pre-submission for review, and you don't even know how to advise that person anymore," she says. "That's when the form needs to be rewritten."

Glacken enlisted the help of the medical college's librarian, who also had served on the college's IRB for close to six years.

Ellen Schellhause, MSLS, health sciences librarian at the University of Illinois College of Medicine in Rockford, also is a member of a health literacy group on campus.

"We use principles of health literacy as we write these documents," Schellhause says. "I volunteered to head a subcommittee on the documents."

Here are some of the ways Glacken and Schellhause revised and improved IRB forms:

*** Take existing university forms and tailor them for the campus:** The University of Illinois had developed human subjects research forms for use by any of its satellite campuses. But as often happens with forms designed to work for a variety of groups, these contained features that were not relevant at the Rockford campus, and so the forms needed to be tailored to fit, Schellhause says.

A small committee met to go over the current forms and identify ways to improve and simplify them.

"We used a laptop computer and projected the forms on the wall, putting them where everyone could see them at one time," Schellhause says. "We identified themes as we were doing this."

The committee also sought logic in the forms, asking questions such as, "What do we need to see first when submitting a form?" she explains.

"The number one thing we wanted in the forms was clarity, but we changed them also to ensure we had a logical flow," Glacken says.

"There's only one of me on the Rockford campus, so that means in terms of man hours that it's very critical to my survival that I'm efficient," she explains. "If I have to write a request for a modification letter then that's one more hour out of my day."

They decided the first items they needed to see on the forms were the investigator's name, contact information, and qualifications, Schellhause says.

*** Make type, format more readable:** The revised IRB submission forms take full advantage of white space, bullet points, and checklists to make these pages of copy more readable.

"We broke down things into bullet points format so it would make it more logical for people using

the forms to follow what we want them to do, and it's less confusing," Schellhause says.

"One other thing we did was for the more complicated forms, we did very simple checklists," she adds.

"As you print out the form and are filling it out, you can check off items to make sure you've completed everything," Schellhause says. "We've discovered that we have a lot less back and forth between the IRB and investigator because they can check everything themselves to make certain it's included."

*** Make forms ask for information that will save IRB office time:** As they continued to review and revise the forms, they decided it would be very helpful to the IRB office if the forms also listed the researcher's human subjects research protection training and dates, she adds.

"It makes it easier for the person who is checking these if the boxes are right in front of them," Schellhause says.

Although this seems like a very small item, it has a huge impact on Glacken's IRB work.

"Researchers need to be cognizant of their own training dates," Glacken says. "You can spend hours tracking down their training dates."

It was fairly common for a principal investigator or medical student to call Glacken when they're filling out an IRB application to ask her to look up their training dates, a task that might add hours to her work week.

This time-consuming extra work has been eliminated by the form revisions. Now that PIs are required to put their training dates and information on the IRB submission form, they have to do their own research to find the dates. And once they've completed the forms, they have the information readily available on their own computers, Glacken says.

"If you write an efficient form that asks everything from the PI that is critically important for the IRB reviewer to know, then you are forcing them to give complete disclosure," she explains. "This makes less work for me as a coordinator."

*** Collect solid details in IRB submission forms:** "The more detail you have in your application, the more it forces the PI to think about his protocol," Glacken says.

For instance, in the form's section about subject recruitment, the application should ask for details about how recruitment will take place, which kinds of materials will be distributed for recruitment, which venues will have advertisements, etc.

"If you put a place in the application that forces the PI to provide this detailed information, then you won't have an IRB reviewer later saying, 'This is too general — you have to tell me more information,'" Glacken says.

This also prevents IRB staff from having to send out modification requests.

*** Take advantage of electronic form hyperlinks:** IRB offices that have electronic submission forms can cut down on their forms' lengths without sacrificing important information necessary for a minority of studies by using hyperlinks.

For instance, if an institution's researchers rarely recruit vulnerable populations, then it might be overkill to have each submission form feature the same paragraphs and questions regarding the handling of vulnerable population subjects. But a simple 'yes' or 'no' question could serve the same function.

So if an investigator checks 'yes' when asked about recruiting vulnerable populations, the hyperlink could call up the additional information and questions.

"We changed the form so that the 'no' answer came first, so the investigator could easily go to the next question," Schellhause says. "If the answer is 'yes,' then you stop there and go to this other form, filling out an appendix."

Hyperlinks also can be used when there's a need to insert an explanation of research regulatory standards, additional legal language, or explanations for those who might not already know this information, she adds.

*** Train PIs, staff about revised forms:** After the submission form committee settled on revisions to more than 50 different IRB forms, the revisions were reviewed by investigators and others and then sent to the IRB for feedback.

When everyone was satisfied with the changes, they published the new forms on the research Intranet site.

"We started the process back in August, and the last new form went up in December," Glacken says. "It's an ongoing process, so if we find an error, we'll update the form."

What they've found is the new forms have been a good learning tool for new investigators. Some have even said that they wished they'd completed the IRB form before writing their protocols because the form helped them think more clearly and logically about their research project, Glacken notes.

"The form forced them to think about the small details," she adds. ■

Audit helps pinpoint problems with IRB's electronic system

System is fixed, audited, and tested

Electronic IRB systems can be an efficient way to improve human subjects research compliance, but as one institution has found, these also can be a source of compliance problems.

The Cincinnati Children's Hospital Medical Center recently conducted a compliance audit that identified a recurring electronic IRB system problem.

"We received a question from the IRB manager about documentation discrepancies, and she asked us to perform an audit to confirm the actual number of these discrepancies," says **Dawn Lowe-Gooden**, CQA, CTSB, MS, research compliance manager in the hospital's office of research compliance and regulatory affairs.

There were automatic activities conducted within the IRB office's electronic submission system that resulted in inaccurate approval and informed consent form documentation dates, says **Benjamin R. Byington**, BS, research compliance specialist.

The IRB manager wanted compliance specialists to verify the cause of the discrepancies and the extent of the problem.

"I was given a query of all studies that involved informed consent, and I went from study by study to verify actual consent approval dates versus actual IRB approval dates to make sure they coincided," Byington says. "I looked at the header, the study number assigned, and the date it was approved by the IRB to use that consent document."

The problem occurred when there were open amendments in protocols.

"When you have an approved and active study in the electronic system and you submit an amendment, the system makes a copy of your currently approved study and all documents and makes it available to the researcher for submitting changes to the IRB," explains **Jeremy Corsmo**, MPH, CIP, director of the office of research compliance and regulatory affairs.

The electronic system had a problem reconciling the approved version of the study and amendments with the continuing review process when done in parallel, he explains.

When the continuing review process was completed and the informed consent forms were updated, the electronic system plugged in the old consent dates on the revised forms, Corsmo says.

"What we were displaying to researchers and on the front page of the system were consent forms that were old, plus outdated approval dates," he says. "It was displaying the expiration date from the previous period and not the new dates issued through the continuing review process."

The IRB staff discovered this through the office's normal quality assurance process.

Byington audited the electronic system forms, looking at each study that had consent forms. Plus he looked at continuing review forms and standard communication between researchers and the IRB office.

After the compliance office identified the problematic dates and process and told the IRB office how to fix these, a manual fix was made. Byington's audits showed that the manual fix reduced the error rate from 15.8% at the time of the first audit to 4.6% at the second audit.

"Over time the 4.6% will be fixed," Byington says.

"Immediately following the 4.6% error rate, we put in internal quality steps on consent forms and an amendment of continuing reviews and work flows in our system," Corsmo says.

Along with these manual improvements, the IRB office also brought in information technology staff to fix the electronic glitch.

"We have a dedicated information systems team who supports our function," Corsmo says.

They expect the electronic fix will bring the error rate to zero, Lowe-Gooden notes.

Sometimes electronic compliance issues can be the most challenging to anticipate, identify, and fix. The compliance office tested the fix created for the electronic system to make certain it would hold up.

"It's really hard in an artificial testing environment to come up with every different scenario in the IRB world," Corsmo says. "We put our heads together to come up with whatever scenario we could think of to break the system, and our testing environment proved the fix was okay."

When a compliance office is implementing an

electronic solution, it's important to be careful of unintended consequences and know that the electronic system is just following the steps, he notes.

When working in the electronic world, one has to think about the steps of convenience built into the electronic system and how these occur below the radar, Corsmo says.

"Whenever you put in place a new electronic system, you should have a test phase where you input test data and see what happens as you are validating the system," Lowe-Gooden suggests. "You need to see if it does what you intend it to do."

And the same is true when an electronic system is revised to fix a glitch.

"The way it's fixed now the system won't allow this error to occur," Corsmo says. "We haven't done another comprehensive audit yet, but I feel confident that this particular problem is solved." ■

Nurture input from community members

Go beyond informed consent duties

The protocol review discussion will benefit greatly from the questions and input of IRB community members. But this resource too often is underdeveloped as the scientific experts on a board dominate discussions.

What's lost is a diversity of opinion and, sometimes, a true understanding of the risks any particular study poses.

"IRB community members tend to get shunted into things they're going to be 'good' at, such as doing the consent form," says **Bruce Gordon**, MD, FAAP, professor of pediatrics at the University of Nebraska Medical Center in Omaha, NE. Gordon also is chair of the UNMC IRB and chair of the Joint Pediatric IRB, as well as professor of pediatric hematology/oncology and stem cell transplantation.

"But the informed consent form is not the community members' only role," Gordon says. "They're not just responsible for reviewing consent forms; they're responsible that the protocol satisfies each of the 111 criteria [for IRB approval of research]."

Gordon recommends that IRB chairs nurture their community members by encouraging them to ask questions and by giving them time to understand the answers.

"As chair, you have several responsibilities, and one is to be the regulatory guru, making sure things are done right," Gordon says.

Another responsibility is to make certain all voices are heard at IRB meetings by knowing the board's personalities and dynamics and how to best use each person's strengths, he adds.

"What we tend to do as chairs is grease the squeaky wheels so that those who yell the most get the most attention," Gordon explains.

"So the community member sits there quietly and gets ignored by everyone," he says. "So you need to give that person the assistance they need."

Another way to look at the community member's role is to think about how the protocol should be comprehensible to everyone on the board, including the non-scientist members. And if something in the protocol is not clear, then everyone benefits from having community members who speak up with questions.

One strategy for encouraging these questions would be to distribute information about the federal criteria for IRB approval of research and ask IRB members, along with the community member, to ask these questions of every protocol.

Gordon offers these examples:

* How, where, and when should consent be obtained?

* Is the location for informed consent conducive to thoughtful consideration?

"An application should include this information, or no one on the board should approve it," Gordon says. "And if the community member doesn't understand, then it's his or her responsibility to ask."

Often, investigators leave out some of these details, and the investigators on an IRB believe they know what the investigator plans because of their own past experience. So it's up to community members to point out that no one really does know what will happen unless the investigator clearly states it in the application, he adds.

The IRB chair's and board response to this question from a community member should reflect their respect for that person's input, perhaps with someone saying, "I don't know and haven't thought about it that way — that's a really good question, so let's get back to the investigator," Gordon says.

Other questions might be these:

* Who has access to the study's data?

* How will data be discarded?

Answers to these questions might be written into a protocol in a way that community members do not see it, so someone else on the board should

Study finds way to improve community research partnerships

A recent study details strategies for improving community-based participatory research (CBPR) partnerships by training local leaders in research practices and human subjects research protection.[1]

With CBPR partnerships, local organizations can improve their ability to seek grant funding and conduct independent research and improve perceptions of research among marginalized communities, including immigrant populations.

Investigators developed a three-pronged intervention that promotes education, training, and dialogue about human subjects protection. They worked with local leaders to design an occupational health assessment for immigrant workers in Somerville, MA. The project included training bilingual teen educators to conduct surveys within the immigrant population as a way to build trust and bridge cultural barriers.

The community education included providing education about historical examples of research abuse, followed with examples of how IRBs work and why research subjects now have much stronger protections against harm.

Researchers acknowledged how immigrant populations face unique risks when participating in an occupational health study, including risk of legal action, risk of alienation from peers, and risk of exposure in the cases of undocumented individuals.

The study recommends that IRBs involve community partners as early as possible to promote greater understanding and cooperation, and it acknowledges the importance of having constant communication between IRBs, community partners, and researchers.

REFERENCE

1. Hyatt RR, Gute DM, Pirie A, et al. Transferring knowledge about human subjects protections and the role of institutional review boards in a community-based participatory research project. *Am J Pub Health*. 99(S3):S526-S531.

offer an explanation, Gordon suggests.

"Or if they don't see the answer in the protocol, then the board should not approve it," he adds.

Another good question might be this:

* Is inclusion of vulnerable subjects necessary?

"The community member, like other IRB members, has to understand why their inclusion is necessary," Gordon says.

Community members also are the ideal people to ask questions about risk. If a protocol indicates that a particular procedure is minimal risk, and the community member cannot see why it's only minimal risk, then he or she should ask about this.

Either the protocol itself or someone on the IRB should be able to explain to the community member's satisfaction why a certain procedure poses minimal risk, or else the protocol should not be approved as it is, Gordon says.

The main point is that community members should not be compartmentalized and given their individual tasks. They need to see each of the IRB protocol approval criteria and encouraged to speak up if they don't understand something the investigator has put in the application, he notes .

"If the community members can't say they're satisfied with the answers, then they can't vote for approving a protocol," Gordon says. ■

CNE/CME Objectives

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

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

Physicians and nurses participate in this medical education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue.

COMING IN FUTURE MONTHS

Make good use of electronic IRB member roster

Reduce impact of undue influence on enrollment

Educate about informed consent with flare and role-playing

Trials that change: Adaptive design and IRBs

CNE/CMEquestions

17. A research and family liaison (RFL) program was introduced because of concerns that families needed support, but a decision was made from the onset to:
A. use the RFLs as benign "spies."
B. not have the liaisons report directly to the IRB.
C. assist only families with language translation issues.
D. encourage families to recruit friends and relatives

18. In a study of informed consent conferences for pediatric research, in about what percentage of conferences were the potential costs or expenses of participation explained verbally to families?
A. 20%
B. 50%
C. 80%
D. 100%

19. Parents of severely ill neonates understandably lacked the ability to make an informed research decision due to the stresses of their situation.
A. true
B. false

20. One good strategy in improving IRB submission forms is to ask for more details about subject recruitment. Which of the following is a good question to ask of principal investigators?
A. How will subject recruitment take place?
B. What kind of materials will be distributed for subject recruitment?
C. What type of venues will have advertisements for subject recruitment?
D. All of the above

Answers: 17. B; 18. A; 19. B; 20. D.