IRB ADVISOR

Your Practical Guide To Institutional Review Board Management

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Current EHR rules present dilemma

How much access should investigators be given?

Some of the latest versions of electronic health records have created logistical dilemmas for research institutions as they find that providing access to information is more difficult for research monitors, researchers browsing for information about potential subject pools, and other activities.

"It is a very hot topic," says **Jennifer Niemeyer,** clinical research manager for Ohio State University Center for Clinical and Translational Science in Columbus.

The OSU facility uses EPIC for its electronic records, and Niemeyer has fielded calls from different institutions about how to handle its security and privacy features.

"We're struggling with the issue of using electronic medical records for screening for studies," Niemeyer says. "We take this very seriously, and before we grant access to the medical record for research, we make sure there are several components checked off."

Human subjects protection offices are developing new procedures and guidelines for how the records can be accessed. In other cases, such as using EHR databases for assessing potential study feasibility, some institutions are taking a wait and see stand, restricting access to identifiable information until there are clearer guidelines from the federal government on how such data should be handled.

The U.S. Department of Health and Human Services' proposed rule changes to the research Common Rule would add specified data security protections to research. These would be calibrated to the level of identifiability of the collected information, according to the Advanced Notice of Proposed Rulemaking (ANPRM) for Revisions to the Common Rule, published in the Federal Register on July 25, 2011. The final rule and precise changes have not yet been announced.

According to an ANPRM fact sheet, the rationale for the change from having no specific data security protections for IRB-reviewed research to having specific protections is because IRBs were not designed to evaluate risks to privacy and confidentiality.

"Setting uniform specific standards will help to assure appropriate privacy and confidentiality protections to all subjects, without administrative burden of needing a specific committee review of each study," the ANPRM fact sheet states.

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HIPAA requires an opportunity for individuals to agree or to object to proposed uses and disclosures of protected health information, according to section 164.510, pages 62-63 of the HIPAA Administrative Simplification Regulation Text, published March 2006.

This requirement includes this wording: "Use or disclosure is sought solely to review protected health information as necessary to prepare a research protocol or for similar purposes preparatory to research."

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Editorial Questions

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The same section also lists IRB waiver criteria, saying it must satisfy criteria that includes the use of the protected health information involving no more than a minimal risk to the privacy of individuals, an adequate plan to protect the identifiers from improper use and disclosure, an adequate plan to destroy the identifiers at the earliest opportunity, adequate written assurances that the information will not be reused or disclosed to any other person or entity and that there is a brief description of the protected health information for which use or access has been determined necessary by the IRB or privacy board.

"There is no need for the IRB to issue a waiver to permit reviews of EHR for work preparatory to research," says **Mark Schreiner**, MD, chair of the committees for the protection of human subjects at The Children's Hospital of Philadelphia. Schreiner also is an associate professor of anesthesia and critical care and an associate professor of pediatrics at the University of Pennsylvania School of Medicine in Philadelphia.

"The investigator is permitted under HIPAA to retain subject's PHI — the minimum necessary — for later recruitment," Schreiner adds.

Privacy issues arise when hospital physicians are asked by sponsors whether they're interested in a particular study, and the doctors need to check medical records to see how many patients might be eligible, explains **Cindi Zech**, IRB specialist at Lakeland Health Care in St. Joseph, MI.

"The sponsor might say, 'I have a study if you're interested, and we're looking for sites with females between 40 and 50 who are treated with Metformin,'" she adds. "The physician looks in the electronic records and types up a report saying there are 100 in the system."

Then the sponsor might name the hospital as one of its study sites, and privacy troubles begin: "How do you contact those patients?" Zech says. "Investigators can do the feasibility part of it, but they can't contact patients; the feasibility part is all de-identified."

Physicians can contact their own patients, but they are not entitled to access to the health system's patients, she adds.

"Our hospital is going to be looking at that," Zech says. "We're waiting for OHRP [Office for Human Research Protections] to say if this is okay or to say that this is what you can do and can't do. Then we'll look at our policy and see if it needs revisions."

Lakeland Health Care's current policy does not permit physician researchers to contact patients who are not their own. They can find out how many of these patients are available, but they're not permitted to invite them to volunteer for the study, Zech says.

At OSU, investigators can view reports on their own pool of patients, but not on the university health system's entire pool of patients. They also can ask other physicians to inquire of their patients about the study, but they cannot approach that doctor's patients directly, Niemeyer says.

"We're very concerned about the idea of patients being approached by people they do not know," she adds.

These EHR issues involving privacy also can create conflicts when study monitors and others outside an institution need to check records.

"Things are getting stricter all the time with the way electronic health records work," says **Renee Hendrickson**, RN, a study coordinator with Altru Health System Research Department in Grand Forks, ND.

"We've had some monitors who are afraid to access records even though they're in read-only format," she says. "They want to sit with us and have us log in and out of the record for them."

While that doesn't happen often, it has occurred since the health system moved to full electronic records, she notes.

Altru Health System has been proactive in developing policies and procedures for accessing electronic health records. Employees, monitors, accreditation surveyors, and any other people who need to view the records first have to look at the system's policies and sign a log book to show they are aware of the policies and procedures, Hendrickson says.

"The more that facilities use electronic health records, the more standard it is becoming to have policies and procedures in place," she adds. ■

Ethical issues and social injustice

CABs could pose new challenges

Research institutions occasionally have studies that involve a population or topic that brings up issues of social injustice, such as studies involving war refugee populations or pediatric HIV foster children. A typical response is to seek input from a community advisory board (CAB), but this might not answer all ethical dilemmas, an expert says.

"There can be problems with community advisory boards," says **Ross McKinney**, MD, professor of pediatrics and director of the Trent Center for Bioethics, Humanities, and Medical History at Duke University in Durham, NC.

"They're filled with people with the strongest opinions, and they might not share the community's opinions," McKinney says. "They may be a vocal subset; so how do you get a representative group of the community?"

McKinney has been involved with pediatric HIV/AIDS cases, and he has observed how CABs designed to represent HIV/AIDS populations, including the low-income, minority children he saw, were instead filled with non-minority members who came from middle- or upper-middle-class backgrounds.

"Our CAB had nice people who tended to be people who were more adherent with their treatment, more middle class, and who were better able to come to meetings," McKinney says. "It was very hard for a lot of our families on the margins to be involved."

The ethical dilemma with this community advisory board that did not truly represent the community being studied was that the members did not share the unrepresented group's concerns with imprisonment, homelessness and other major problems, he explains.

"Worrying about medication turns out to not be high on their priority list, and worrying about future medications is even lower on the list," McKinney says. "My general sense is if you want to get to the broad community, it is very hard to get that balanced community engagement from the CAB."

The studies typically did not have funding available to pay CAB participants enough to attract a wider range of members, but even if they did there are some ethical challenges with this approach, he says.

"Whenever you pay someone for their time it becomes trivial for the rich and important for the poor," McKinney says. "If you make it important for everybody, then you're paying people proportionate rates based on their day's wages; then one person receives a lot of money to attend the meetings."

Since funding for paying CAB members typically isn't available, investigators and IRBs have to make use of community advisors who sometimes have a superficial awareness of the community's true needs, he says.

This makes it important that researchers, social workers, and faculty who sit on the CAB help keep the board's focus within the scope of identified community concerns.

"You have to keep it within the scope of what is reasonable and possible," McKinney says. "Your worry is that you will steer them so much you will lose the point, but you have to keep people focused and note where there are differences in the board's opinions and what you've learned about the community's concerns."

There are other issues involving social injustice juxtaposed with ethical considerations that IRBs can encounter. McKinney offers these two case examples:

• **Children in foster care:** Occasionally, there are studies enrolling children who are in foster care.

"In the early days of HIV treatment, the only way you could obtain access to medications — and this still is the case with some cancer drugs — was to participate in research," McKinney says.

"When a child is in a foster care system it becomes a tremendous amount of work because of the regulatory burden to enroll a foster child," he explains. "The regulations require you to have the signature of the authorized head of the department of social services, a guardian ad litem or other advocate, both foster parents, and both parents, even if they didn't have custody."

The ethical dilemma from the IRB's perspective is that if investigators chose not to enroll this population or failed to obtain permission to enroll foster children because of incomplete paperwork, then the children were deprived of the only potential treatment that might save their lives.

"Don't they deserve access to the medication that in many cases was being studied just to prove the drug was bio viable in children, as well as adults?" McKinney asks. "In the case of the HIV drugs, we knew they worked."

This ethical dilemma also caused some long-term headaches for research institutions in New York, he notes.

Some institutions got into trouble because they forgot to have guardians ad litem sign the informed consent forms, he says.

"There was a lot of controversy over that 10 years ago," he says. "They had to dig through 15-year-old records to see if we had a foster kid and whether there was guardian ad litem or not."

• **Parents' privacy versus public safety:** The three worst privacy cases McKinney can recall involved adopted children who had contracted HIV at birth.

"The mothers did not want to tell the children they were HIV-infected because it would mean the children would understand that either the parents also were infected or that they were adopted," he explains.

The children were given treatment since birth, but they were told only that they had a blood disease. But the ethical dilemma arose when the children reached their teen years and showed signs of becoming sexually active.

"We had to tell the children they were HIV positive," McKinney says. "In the relative hierarchy of ethical priorities, the possibility that one person would endanger another person was a position we could not support."

The institution was not sued, but the children's mothers were angry, and the children lost respect and trust for their parents, he adds.

Although this particular case did not involve research, it illustrates what can happen in study situations if there are conflicts between what investigators, IRBs, and research institutions believe is the ethical and correct way to handle disclosure to participants who are minors and what the children's parents believe is best.

These types of cases also show how difficult it can be to handle enrollment and informed consent in the context of social injustice, McKinney notes.

"In the early days of HIV we were dealing with children from drug-abusing families or children who acquired HIV from child abuse," he says. "We had trouble dealing with families because of the drug use and all that came up with it, and sometimes there were adolescents who ended up in jail." ■

BEST PRACTICES SPOTLIGHT

IRB's submission flowchart makes PI decisions easier

Sometimes an IRB's caseload grows so big and complex that new processes have to be implemented or the workload is unmanageable.

When this proved to be the case for the institutional review board at the University of Tennessee Graduate School of Medicine in Knoxville, the IRB developed a submission flow chart that helped cut down on time and IRB office effort.

The IRB handles a wide array of study submissions, including reviewing studies from the university health system, the medical school, and from individual physicians, faculty, residents, and staff.

"We also have faculty from the University of Tennessee on the main campus submitting," says **Reni Leslie**, CIM, IRB associate director.

"It got to the point where we had to have a process that would expedite the approval process," she says.

The IRB office and institution's compliance officer met and decided a submission flowchart would be the best solution, Leslie says.

"I spent time online looking at the processes of other IRBs, pulling samples from different sites," she explains.

The result is a colorful, one-page flow chart that provides simple, concise instructions on what level of submission and which forms are needed.

Here are some sample items on the flow chart:

• Projects of non-GSM/non-UHS investigators must be approved by UHS director of research compliance;

• **Exempt Review** (may be submitted any time):

– Less than "minimal risk" to human subjects; Example:

– Anonymous response survey, focus group or questionnaire, case reports;

– Working with a completely de-identified (anonymous) secondary data set;

• **Expedited Review** (may be submitted any time)**:**

– "Minimal risk" to human subjects; Examples: Prospective or retrospective chart review, surveys/ questionnaires collecting limited personal identifiers or health information, any intervention or interaction with the subject;

• **Full Review** (see the IRB meeting schedule for pre-review and submission deadlines for full board reviews):

– More than "minimal risk" to participants):

– Any research project involving human subjects not covered under any other review categories;

– Contact with vulnerable populations;

– Working with data that can be traced or linked to individual participants;

– Interventions involving physical or emotional discomfort.

The submission flowchart also contains information about CITI training, definitions of minimal risk and vulnerable populations and details about the forms and copies that need to be submitted.

"We put the flowchart on our website, and it's basically self-explanatory," Leslie says. ■

Include criteria for review in policy manual

IRB chair finds helpful guide

If an IRB's policy and procedures manual needs updating, it might be time to write or revamp the section on criteria for review.

It's important to have these criteria in writing and with references or links to the regulatory sources so investigators and others can see where they come from, says **Lawrence Stark**, PhD, an associate professor and IRB chair at the Southern California College of Optometry in Fullerton.

Stark reviewed the IRB's policy manual a couple of years ago and found that some items were clear and provided all of the necessary information. But as he worked on revising and improving it, he found that criteria for review information came up short.

"I think the reason why the criteria for review is so difficult to explain is because there are so many different aspects people take into account when reviewing a study," Stark says. "And so many things happen in daily life that you can't account for every combination."

This leaves the person writing the update with the question of whether to write specific details into the criteria or simply to keep the criteria general, stating something about how the criteria for review are obtained from relevant laws, ethical principles, and other sources, Stark says.

This dilemma is partly a writing issue, he notes.

Once Stark found guidance for writing effective policies and procedures, the goals for writing criteria for review began to form more clearly. Stark read a book, published in 1998 by AMACOM and written by Nancy J. Campbell, titled, *Writing Effective Policies and Procedures: A Step-By-Step Resource for Clear Communication*.

"The book was interesting because in the first chapter, Campbell mentions the very questions I was having," Stark says. "Also, it struck me that writing these criteria requires a special type of writing I've never done before: technical writing, and there's a skill to doing that."

The key to rewriting the policy and procedures manual is to include general goals for the project and decide how specific the manual will be with regard to procedures, Stark says.

"It could become problematic if you have to describe every detail," he adds.

Another thing to keep in mind is that each policy and procedure comes from some identifiable source. The writer should know where they come from, although explaining this in the manual might not always work toward creating an effective and useful guide, he says.

"If I put in cross-references to a common procedure then it starts to get convoluted," Stark explains. "All the cross-references can become a little overwhelming."

Stark has found a solution to this dilemma by creating a format for each section in which the policy is described first and then the rationale is described, with subheadings. The section might also refer to a form that needs to be filled out.

For example, there is a policy for reporting and handling adverse events. The adverse event form has

a series of questions and sheets to be filled out. In an electronic policies and procedures manual, this form could be accessed through a link.

When Stark completes the policy and procedures manual revisions, he plans to post it on the IRB's internal website in a PDF format for investigators and others to download and review.

"I've been reviewing parts of the policy manual and will make it more plain," Stark says. "Then I'll get input from the IRB members about what should be included in the manual." ■

AASPIRE addresses adult autism research

Communication and partner training are key

Involving a disability community in research from its inception can help shape the research so that it's more successful and addresses the community's needs better.

It also can better protect subjects, making informed consent more understandable and the study more respectful of participants. But it requires flexibility on the part of both researchers and IRBs.

At the Academic Autistic Spectrum Partnership In Research and Education (AASPIRE), research partners include university investigators, adult autistic self-advocates and parents of autistic individuals as well as individuals who straddle those lines, says AASPIRE's co-director **Christina Nicolaidis**, MD, MPH, an associate professor of medicine at Oregon Health and Science University in Portland.

Nicolaidis notes that AASPIRE's co-director, Dora Raymaker, MS, is an autistic self-advocate and scientist.

"It's such an advantage to have somebody who understands the science as well as she does but who also is an active member of the community," Nicolaidis says.

Currently, Nicolaidis says, the research group focuses on adults with autism, in part because much of the autism research currently being conducted is geared toward children.

"What ends up happening is that with everything focused on children, there are great gaps when it comes to adults," she says.

Nicolaidis says many current autism studies look at what causes autism, rather than how to improve the lives of people, particularly adults, who live with it.

A 2011 report by the federal Interagency Autism Coordinating Committee bears this out. Out of $314 million in public and private autism research funding in 2009, only 3% focused on services to people with autism, and less than 1% focused on what the future holds for autistic adults.

"For the autistic self-advocacy community, their main interests are around 'How can our lives be better?' And only a tiny proportion of money goes toward that," Nicolaidis says. "From the community's perspective, they're frustrated that so much of the money is going to questions that they don't feel are particularly helpful.

"There's a real fear in the self-advocacy community that the ultimate goal of a lot of this research is to create a world that doesn't have autistic people in it," Nicolaidis says.

AASPIRE's work has focused on improving health care services to autistic adults, fostering social support through the use of the Internet and studying violence against people with developmental disabilities.

"If you start with the community from the beginning, it's going to shape different questions," Nicolaidis says.

Unique challenges

Nicolaidis has worked with a number of community-based groups in research projects, and says working with autistic adults poses many of the same challenges — achieving true informed consent, providing community partners with necessary human subjects protection training and helping them navigate the bureaucracy of institutional research.

However, autism does provide different wrinkles to those challenges.

For example, the solution many investigators and IRBs find for informed consent problems is to simplify the language by using less complex words and shortening sentences. However, this approach doesn't necessarily improve comprehension for autistic subjects, Nicolaidis says.

She points to an experience she had crafting survey materials for a subject group that included both autistic people and people with intellectual disabilities.

"As we simplify language and take away complicated sentence structure, that helps the people with intellectual disabilities understand the materials," she says. "But it actually makes it less accessible to many of our partners and participants on the autism spectrum. What they need is a lot of

precision and specificity.

"If you take away a complicated word and substitute it with a very simple word, sometimes you take away that precision," Nicolaidis says. "If you turn a longer sentence into a shorter sentence, you've also taken away some of the details that they need."

She says her team addressed this problem in a computerized survey by using embedded hotlinks to allow subjects to click on a word for a better definition or for more detail. They used graphical representations (a cylinder filled to various levels) to illustrate concepts such as "some of the time" or "most of the time," which can be hard for some people to calibrate on their own.

When determining subjects' capacity to give consent for research, NIH guidance (http://grants.nih.gov/grants/policy/questionablecapacity.htm) notes that consent capacity varies depending not just on the subject but on the complexity of the study.

Nicolaidis says determining consent capacity for an autistic person is often complicated by communication difficulties.

"If we can be thoughtful about the best way to communicate information, then I think we have a greater chance of allowing people the opportunity to be able to make decisions for themselves," she says.

She notes that the OHSU IRB has been flexible about the template required for informed consent.

"Luckily, I work with a wonderful IRB," she says. "I know some IRBs are more hesitant to change their legal language, but my IRB has been extremely reasonable and understanding about the basic argument that you're going to get better informed consent if subjects understand what you're talking about."

Community training

Nicolaidis says one of the most time-consuming parts of conducting community-based research with autistic partners has been helping them navigate the IRB's bureaucracy. "I can't count the number of hours my research assistants have spent trying to support our community partners as they've figured out the whole electronic system, and taken the human compliance courses."

Because AASPIRE is a far-flung organization with partners around the world, much of this support has to be conducted via videoconferencing. The difficulty generally hasn't been in understanding the material, but in the executive functioning needed to carry out a number of different steps.

The partner must get an ID number for the institution's system, register with the electronic IRB system, attest to any conflicts of interest (which Nicolaidis says are usually non-existent) and sign up for online training, all on different websites.

"My research assistant is usually on Skype with them as they're trying to do the pieces, saying, 'OK now you have to click here, now you need to open this,'" she says.

Nicolaidis notes that this problem isn't unique to autistic community partners. She says the bureaucracy is built for academics who are used to moving in that world, and many different types of communities may find it daunting.

She frequently consults with the analysts and chair at OHSU's IRB to talk through projects before she ever submits them.

"There's a lot that ultimately needs to be flexible, having IRBs understand that CBPR has different constraints, that we're going to be putting a lot more modifications into a CBPR project as we're developing things with our partners," she says.

She says that as an IRB reviews a community-based project, particularly with autistic partners, it should be looking closely at the community partners.

"Have they involved any actual self-advocates?" she says. "A lot of projects will say they're working with communities, but the community is made up exclusively of family members."

Nicolaidis says the IRB should ensure that there's been an effort to make reasonable accommodations to allow people to participate in the study. Is the language accessible? She says some autistics are better able to communicate on a computer than in a face-to-face discussion.

"So many studies just assume incompetence and go to proxies," she says.

That approach is not always appropriate. Nicolaidis points to a study she conducted about violence against people with disabilities. Her group made a conscious effort to create an anonymous computer survey that allowed participants to complete it without the help of a proxy or even a research assistant, since the assistant would have been required by law to report any abuse uncovered by the survey.

And she says the framing of the study should reflect the community's concerns. Nicolaidis says many projects are based entirely on learning about autistic subjects' deficits — what they can't do — rather than looking at both deficits and strengths.

"I'm not saying that everything has to be strength-based, but when it's 100% deficit-based, all doom and gloom, that's ultimately hurtful," she says. ■

Cancer trial subjects define burdens, benefits

Symptoms, economic concerns play role

When reviewing cancer clinical trials, IRBs must weigh the risks and benefits to potential participants. But it's not always clear what participants themselves consider to be a risk or a benefit of their enrollment in a study.

A new survey of cancer patients explored that topic in detail, asking open-ended questions to let participants themselves define those terms.

Connie Ulrich, PhD, RN, FAAN, an associate professor of bioethics and nursing at the University of Pennsylvania School of Nursing, says the idea of participants' perceptions came to her when she was a post-doctoral fellow at the National Institutes of Health.

"I started thinking about this issue of respondent burden and what did it really mean," she says. "And there wasn't much in the literature to help us understand that particular concept."

So her study team recruited 32 cancer patients taking part in Phase I, II and III trials. They asked them to describe their experiences, what they saw as benefits and burdens, and how they weighed the two in making a decision to enroll.

The resulting study was published in a recent issue of the *American Journal of Bioethics Primary Research*.

Some of the results were unsurprising. Participants complained of nausea, fatigue and other physical symptoms of the treatments they were receiving. They discussed the personal inconveniences associated with a trial, including travel and time away from work, as well as the burden of paperwork, particularly informed consent. Benefits included a sense of accomplishment and control over their situation, as well as free care and close monitoring of their condition.

Participants talked about the influence of their families and their doctors on their decisions to enroll, and many described spirituality as an important component of their decision-making.

But the results also raised some new questions for researchers: Do some patients rely too much on their doctors' opinions? More than a third of those asked expected some benefit from their participation — are too many patients confused about the essential fact that they are participating in research?

Ulrich says this survey begins to scratch the surface of what goes into a participant's decision.

Influence of physicians, cost of care

"There are so many concepts that came out of the study that need much more exploration, which is terrific, but that doesn't give us a definite answer at this point," she says. "It's exciting from that standpoint, but I would also like to know."

For example, she notes that two-thirds of the respondents described their physician as either "moderately" to "extremely" influential in their health care decision-making, including decisions about research participation.

"I came away from this trying to have a better understanding of what the role is of trust with regards to patients understanding the risks and benefits," Ulrich says. "There's a lot now in the literature about shared decision-making, but I'm not convinced how much control patients want to have over the decisions that they make related to their research participation."

Another area that raised red flags was the economic burden of health care, and the effect that may have on patients' deciding to enroll in a trial.

One patient interviewed about this subject told researchers, "To be honest, part of being in a clinical trial — I don't have to pay my co-pay. Is that awful?"

"Economic burden was a major factor that came out in our study," Ulrich says. "People were worried about the cost of cancer care. We need to further explore that."

The team also was concerned about responses that pointed to possible therapeutic misconception. Because the survey was open-ended, there were no questions specifically attempting to measure this element, but Ulrich hopes to receive a grant soon that will allow her to go into this and other issues in greater detail.

Role of spirituality

She says the issue of spirituality "jumped out" at researchers as they looked at the responses to the survey. Seventy-four percent of respondents said spirituality was very important to them, with some saying that it helped them deal with the uncertainty of the cancer diagnosis and treatment.

"So they had trust in a higher being, so to speak, but they also had trust in their physician/researcher, so both of them could coexist at the same time," Ulrich says. "There's been some literature to suggest that spirituality is associated with quality of life in cancer patients. We probably need a

better understanding of what exactly is the role of spirituality in cancer clinical trials — how that helps patients cope with their illness and also the research participation aspect of the trial."

Ulrich, who serves on her institution's IRB, says these results raise interesting questions about the role of the IRB, particularly in situations where participants seem not to be truly weighing both benefits and burdens of research participation. One respondent candidly said, "I didn't look at the burdens at all — I just looked at the benefits."

"I think we [on the IRB] will just probably continue to be vigilant in looking at those risks and benefits, and how we think about weighing those risks and benefits for the particular population under study."

She says she hopes information from this and future research will inform strategies to help patients who are considering enrolling in trials.

"We know that less than 5% of [eligible] adults actually participate in cancer clinical trials," Ulrich says. "Maybe this will help us better help patients who are considering enrolling in a trial to know what the issues are that might be relevant for them."

REFERENCE

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Using EHRs in research poses privacy concerns

Overcoming barriers for use

Electronic health records (EHRs) offer a rich resource for facilitating clinical research by identifying patients who fit the eligibility requirements for a study and allowing researchers to collaborate with primary care physicians to recruit them.

But taking advantage of this resource requires researchers to navigate a complicated path of regulations and institutional policies intended to protect patient privacy. And those policies are not always consistent, says **J. Thomas Bigger**, MD, a professor of medicine and pharmacology at Columbia University in New York City, who serves on the faculty of the university's Center for Bioethics.

"The regulations are not that crystal clear," Bigger says. "They tend to be interpreted different ways in different institutions. It depends on who's doing the local regulations, whether their perspective is to protect the institution at all costs or whether they have a broader view of it."

Bigger and **Chunhua Weng**, PhD, MS, an assistant professor of biomedical informatics at Columbia, say human subjects protections concerns can be addressed while still making it easier for researchers to find and approach potential research subjects.

They say policymakers can assist by clarifying HIPAA privacy rules and harmonizing them with other federal human subjects protection regulations. IRBs, Weng and Bigger say, can do their part by ensuring that local policies are not so stringent that they preclude commonsense research activities, particularly those preparatory to the research itself.

"We observe a lot of inconsistencies regarding who has access to patient data for trial pre-screening," Weng says.

Their recommendations for facilitating the use of EHRs in research are included in an article in a recent issue of the Journal of the American Medical Informatics Association[1].

Identifying potential subjects

Weng and Bigger note that IRB concerns are not the only barrier to more effective use of EHRs in research. They identify other problems, such as the completeness and accuracy of the records and the drain on physicians' time involved in assisting researchers. Bigger, himself a clinical trial researcher, says the days are gone when he could buttonhole a colleague at the elevators and pitch a trial to him without interruption.

"Now, when the first elevator came, they'd be gone," he says. "They're late for something. They're always late for something. They don't have the luxury of time they used to have."

But even that problem, he says, can be eased by relaxing the restrictions on who can view medical records in order to determine whether patients are eligible for trials.

Currently, Weng says, her own institution's IRB can grant waivers for access to EHRs to search for potential subjects. This information is usually de-identified, but can still prove useful — with physicians' cooperation, Bigger says.

"You can search the medical records to see how many eligible patients each clinician might have. [The clinicians] get the list with names and IDs on them, while the researcher just gets the counts — Clinician A has 60 patients, Clinician B has 12.

"You can see that some clinicians have so few eligible patients it wouldn't be productive for

anybody concerned to pursue it any further," Bigger says.

And he says it is important for researchers to be able to communicate with physicians to determine if patients who are found electronically are really a good fit with a clinical trial. Physicians often know information about patients — terminal illness, alcohol use, non-compliance with medications — that isn't in the record but may make them ineligible.

"A lot of doctors won't put sensitive stuff in electronic medical records," Bigger says. "But they know the reasons this patient wouldn't be suitable for the trial."

He and Weng say HIPAA regulations would allow this sort of preparatory activity without patient authorization or an IRB waiver, as long as a researcher is a member of the covered entity, but that many institutions interpret the rules more strictly.

Weng and Bigger say some IRBs also impede research by requiring that researchers obtain permission from the patient's primary care provider (PCP) before they approach a subject. Again, they say this is not required under federal regulations.

This can cause problems, particularly if it is not clear from the EHR who is the patient's PCP. Weng says she knows of a researcher who ran into difficulty because a subject had more than one PCP.

"One patient would be involved in a clinical trial study, and then two weeks later, an unknown primary care provider called the researcher and got angry, saying this patient should not be participating in the study," she says.

"There's no clear rule regarding how to resolve those conflicting opinions of different primary care providers regarding research participation."

She and Bigger argue that while a PCP's authorization may be a reasonable requirement in higher-risk studies, it's not necessary for all research.

'Falling into a crack'

Once a patient is actually enrolled in a trial, the privacy rules continue to cause difficulty, they say, making it hard for researchers to access scheduling in order to coordinate research and clinical visits. Just as importantly, researchers often cannot enter data in EHRs, and so can't show, for example, the study medications a patient is taking.

"We see patients falling into a crack, separated by the clinical care team and the clinical research team," Weng says. "Each team only takes care of a patient's certain activities. So it's hard to detect drug/drug interactions between an experimental drug and the regular treatments."

Bigger says there needs to be a better method of sharing information in both directions, between the researchers and the clinicians.

"You may have to do it a little differently with every physician in every study," he says. "But if you don't come to a wide-open communication among all the parties, you're just asking for trouble, of one kind or another — misunderstandings or really serious interactions with the treatments being studied."

They say informaticians could create sophisticated means of allowing two-way communication while protecting patient privacy, but that it likely will require policy changes at the U.S. Department of Health and Human Services level to accomplish.

While much of the burden of solving problems associated with research use of EHRs lies with policymakers, they say IRBs can help by showing flexibility.

"I hope the local IRBs can appreciate the diversity of research settings," Weng says. "Some researchers are clinicians themselves, so they're enrolling their patients or their colleagues' patients. Other researchers may not have a pre-existing relationship with patients. If we just have one single, one-size rule trying to fit it all, that becomes kind of difficult."

REFERENCE

1. Weng C, Appelbaum P, Hripcsak G et al. Using EHRs to integrate research with patient care: promises and challenges. *J Am Med Inform Assoc* 2012 Apr 29 (epub). ■

Training focuses on environmental research

Environmental studies may have ethics needs

Research in environmental sciences, engineering and related fields can raise unique ethical issues that may be unfamiliar to many IRBs, particularly when it comes to community-based research.

An ethics education program funded by the National Science Foundation has created special training materials aimed directly at this type of research, focusing on issues such as cultural competence and community-based participatory research (CBPR).

Dianne Quigley, PhD, adjunct assistant professor of environmental studies at Brown University in Providence, RI, says the project, developed by the Northeast Ethics Education Partnership, applies existing ethics literature more

specifically to these fields.

"Most of the literature on research ethics has come out of the medicine and public health [fields] and moving that over to environmental studies is a lot of work," Quigley says.

She says Brown has the CITI online training course in human subjects protection, but she wanted to go beyond the basic concepts in that training to focus specifically on the type of issues that her students might encounter.

"There are so many case studies in the field that are important to learn from, from each one of these disciplines," she says. "You can make it very meaningful to [students] when you relate it to their field."

So the Northeast Ethics Education Partnership, which includes Brown and the State University of New York College of Environmental Science and Forestry in Syracuse, began pulling together training materials on a variety of topics.

Topics available include:

– Community-Based Research and Environmental Justice Interventions, which examines CBPR best practices, including the importance of community review boards.

– Power and Privilege Issues with Culturally-Diverse Communities in Research, a look at how to develop truly collaborative participatory research by understanding the culture in which it is to be conducted.

– Research Ethics Protections for Place-Based Communities and Cultural Groups, with an emphasis on group or community protections and providing information on international guidelines.

– IRB Challenges in Community-Based Participatory Research on Humans Exposure to Environmental Toxicants, a look at the various issues involved in this type of research, including informed consent, community right-to know, community advisory boards and reporting back of study results.

The IRB presentation, like many of the others, cites specific case studies in areas such as biomonitoring and household exposure studies.

While the materials were developed primarily for use with graduate students, she recently has received requests by IRB coordinators asking for them for their IRBs and for research ethics training at universities.

"That's a wonderful use, we're very happy to serve that," Quigley says.

She says she still has other training topics she plans to address, including one that examines human rights histories of communities being approached for research.

She also plans to continue creating specially-crafted programs for various areas of study, such as engineering.

"I have landscape architecture, built environment, all these subfields in environmental studies," Quigley says. "They will all work in community collaborations, and they like to look at what's from their field. So we're developing PowerPoints that include some of their own field experiences."

The list of training materials that the

CNE/CME OBJECTIVES & INSTRUCTIONS

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 continuing education program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to www.cmecity.com to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly. ■

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partnership is making available can be viewed at http://brown.edu/research/research-ethics/northeast-ethics-education-partnership/training-materials/training-materials

Quigley says those interested in using them can download a request form at that website, and email it to the partnership at NEEPethics@yahoo.com. ■

CNE/CME QUESTIONS

1. Proposed changes to the Common Rule regarding data collection would do which of the following?
   A. Electronic data would need to have a paper back-up in case of system failure
   B. The changes would add specified data security protections to research, calibrated to the level of identifiability of the collected information
   C. All data collected electronically would need to be stored off-site in a place protected from cyber-attacks and natural disasters
   D. None of the above

2. Which of the following is included in HIPAA's IRB waiver criteria?
   A. Use of protected health information involves no more than minimal risk to the privacy of individuals
   B. There is an adequate plan to protect the identifiers from improper use and disclosure
   C. There is an adequate plan to destroy the identifiers at the earliest opportunity
   D. All of the above

3. True or False: Autistic subjects can benefit from more specificity and precision in language in study materials, rather than simpler words and shorter sentences.
   A. True
   B. False

4. How much of 2009 autism research funding focused on what the future holds for autistic adults?
   A. Less than 1%
   B. 3%
   C. 30%
   D. More than 50%

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