CLINICAL TRIALS
ADMINISTRATOR
An essential resource for managers of clinical trials

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IN THIS ISSUE

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Disaster Planning Primer

If disaster were to strike your facility, would you be ready?

Sites impacted by recent disasters share their experiences

Clinical trial sites and research administrators across the country witnessed the devastation caused by Hurricane Katrina with both personal and professional alarm.

Many clinical trial sites in New Orleans and neighboring areas were closed and some may never re-open. Others were moved miles away and are coping with financial stress. Even the larger sites, which have tried to return to business as usual, have found that it's very difficult to contact patients/subjects when the contact information is located in offices that were closed for weeks and when the trial participants have been scattered to cities across the country.

Six weeks after Hurricane Katrina, more than two-thirds of the clinical trial sites in the New Orleans area were not up and running or they were operating on a limited basis, says **Alicia A. Pouncey**, MEd, managing director of Aureus Research Consultants in Metairie, LA. Aureus Research performs contract monitoring of clinical trials.

Some clinical trial staff have lost their jobs because of the disaster, and many others are worried about potential job loss, Pouncey says.

"Medical facilities are trying to maintain care for patients, and clinical trials are way down the pole on what's important," Pouncey says.

The Office of Research Services at the Louisiana State University Health Sciences Center of New Orleans had its operations moved to the Pennington Biomedical Research Center in Baton Rouge, where there is limited office space for temporary use, says **Kenneth Kratz**, PhD, director of the Office of Research Services and the manager and co-chair of two IRBs.

"In the meantime, we had done the office of research services' work over the Internet to the extent possible," Kratz says. "I had evacuated to St. Louis with my family and ended up staying in a house of a friend of a friend in Logansport, LA."

Since hurricane threats are nothing new to Gulf Coast residents, it's not unusual for people to have to evacuate once or more per year, Kratz says.

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Editorial Questions

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"When we left school on Friday before the hurricane, I just figured it was another scare," Kratz says. "I thought we'd leave town and be back in a couple of days, and so I blanked out and left my laptop in my office."

Then Hurricane Katrina struck and it was several weeks before Kratz could return to his suburban home, which had only wind damage. He was able to retrieve his desktop computer from his home. "I was able to contact all of my staff by the second week and had established rudimentary communications with them," Kratz says. "That was one of the most difficult things for everybody — having so little communications capabilities in terms of personal business."

More than six weeks after the hurricane hit New Orleans, Kratz still didn't know the status of all of the research projects.

"If a study is company-sponsored, we hope they have contacted sponsors for those clinical trials, but I don't know whether they have," Kratz says. "We have contract issues, but we don't have access to all of our contracts until we get back into our building in New Orleans."

Meanwhile, Kratz's staff are trying to make contact with principal investigators and find out the status of their studies. The research office manages about 1,500 projects of which 500 to 600 are above minimal risk, Kratz notes.

"All the PIs have been displaced from the city and ended up all over the place," he adds. "Many of our investigators may just now be getting Internet connections back."

The evacuation, which stretched into weeks, has impacted hundreds of research professionals in the region. "There are a couple of hundred research professionals in the affected areas and thousands of clinical research subjects who were recently active in trials," says **Norman M. Goldfarb**, managing partner of First Clinical Research in Palo Alto, CA.

Goldfarb suggests that the clinical research industry can turn this huge disaster into a huge opportunity by strengthening the clinical research community by providing help specifically to clinical trial subjects and research staff.

For instance, many pharmaceutical companies have distributed free medication to people in the impacted areas, and this benevolence should be extended through sites to participants at clinical trial sites in the disaster areas, Goldfarb says.

"This would tell the public that the clinical research industry looks out for study participants," he adds.

Other measures could include having clinical research people donate their frequent flier miles to research peers who have to commute between New Orleans and temporary offices, Goldfarb says.

Goldfarb is organizing a fundraising series of teleconferences in January. The educational sessions will cost $99 each or three for $249, and 80% or more of the money will be directed to a nonprofit foundation to help hurricane victims within the clinical trial industry, Goldfarb says.

"There will be two categories of recipients: staff and subjects," Goldfarb adds.

Registration for the teleconferences is available on First Clinical Research's web site at www.first-clinical.com.

Disaster planning not a priority

Until Hurricane Katrina showed the industry the possibilities of a major disaster, clinical trial sites might have looked at disaster planning as the last item on the priority list.

"We did not give disaster planning any serious thought until Katrina hit," says **Tom Davis**, PharmD, chief executive officer and president of Odyssey Research Services in Bismarck, ND. The company is a site management group.

The most common disasters to strike Bismarck are blizzards in which transportation and power might be impacted for a few days.

"We have a written policy on disaster recovery for our IT systems, but that's not because of the potential for a natural disaster, but because of the nature of computer systems and having systems crash," Davis says. "We're in the process right now of revisiting our disaster plan."

Davis predicts that sponsors soon will be asking clinical trial sites whether they have any standard operating procedures (SOPs) for disaster planning. **(See story on disaster planning, p. 136.)** "I think in the future sponsors will be looking at whether or not investigators have some sort of disaster plan for maintaining the integrity of documents for something such as a tornado or flood or that sort of thing," Davis says.

Goldfarb has written an emergency action plan template for clinical trial sites. **(See excerpt from emergency action plan, p. 138.)**

One of the most important actions a clinical trial site can take is to arrange for an offsite backup of electronic and other data, Goldfarb says. "The industry as a whole doesn't think about this very much, and most study records are stored at the site," Goldfarb says. "So if there's a disaster or emergency the records could be destroyed or damaged or inaccessible because the police won't let site staff back into the building."

While clinical trial and research offices experience difficulty in contacting principal investigators, the PIs may find it daunting to contact their subjects after a disaster, Kratz says.

Some New Orleans investigators opened up clinics elsewhere and have continued with their clinical trials, but many were having trouble finding subjects in the first months following the hurricane, Kratz says.

Kratz spoke with a cancer center's study coordinator and asked how extensively the center had lost contact with patients on clinical trials, and the coordinator told him that in some cases the center had lost contact with 100% of the subjects.

For a contract monitoring service like Aureus Research Consultants, the evacuation posed a less severe hardship, Pouncey says. "For a business like ours we can restart wherever there's an Internet connection and an airport," Pouncey says. "But you have to make provisions for record storage."

When Pouncey evacuated from her home and office, the only things she took with her were her laptop computer, her dogs, insurance papers, and tapes that were the back up for the computer server data.

"I had information in the laptop and server tape that would allow us to do our business somewhere else the next day," Pouncey says.

Pouncey says she's concerned about the personal impact the disaster has had on clinical trial coordinators and other research staff.

"They may be thinking about their home being destroyed, but also wonder whether they still have a job," Pouncey says. "If they haven't heard from their employer, they're in a mental limbo."

Disasters, like other major life crises, bring out both the best and worst in people, Pouncey notes.

While many sponsors and others in the research industry were very supportive after Katrina struck, there was one phone call Pouncey had that was particularly jarring, she says.

"One sponsor called to ask, 'How is our EKG machine?'" Pouncey says. "I think, 'I don't care—I have an employee with 11 feet of water in her house, and it's just a machine.'" Anyone calling from outside the disaster zone should first say, "I hope you and your family and staff are all right," Pouncey suggests.

The research office at Louisiana State University Health Sciences Center is working toward

conducting business as usual and may even open a couple of new studies, but progress has been slow, Kratz says.

"It's dependent on PIs finding a place to work and a place to see patients and subjects and accrue subjects," Kratz says.

"So we hope to get some normalcy back, and that's a common word you hear around here—normalcy," Kratz says. "It'd be so nice to have something normal right now, but we don't have that yet." ■

Disaster Planning Primer

Katrina survivors offer tips on preparedness

Think of all possible scenarios

At least for the next few years the clinical trial industry will view three names as turning points: Katrina, Rita, and Wilma.

The three major hurricanes to hit the Southern United States in the late summer and fall of 2005 will be cited as the reasons sponsors have begun requesting clinical trial sites to provide standard operating procedures for disaster planning, some experts predict.

"Because of the hurricane disasters we're suggesting clinical trial sites could do more to prepare," says **Alicia A. Pouncey**, MEd, managing director of Aureus Research Consultants of Metairie, LA. Aureus Research performs contract monitoring of clinical trials.

"My fear is the sponsor will require more disaster preparedness and that will add more hours to a person's week," Pouncey says. "And the person having to carry it out is the research coordinator, who doesn't have enough time anyway."

Ideally, the sponsor and IRB will share in the responsibility of preparing for disasters, Pouncey says. "The challenge we saw in the Hurricane Katrina disaster was the fine line between a company that wanted data and the one concerned about protection," Pouncey says.

An unexpected consequence of a disaster, such as Hurricane Katrina, has been the reality of decreased revenues coming in to an institution, says **Kenneth Kratz**, PhD, director of the Office of Research Services and manager and co-chair of two IRBs at Louisiana State University Health Sciences Center in New Orleans.

"Obviously, much of our clinical trials and other sponsored research have been put on hold because the investigators either don't have some place to perform the study or there isn't a subject population out there, and there are no new patients to enroll in the study," Kratz explains.

When principal investigators have been proactive and found a new location to conduct their studies, this means the research office is called to help them draft amendments to their original IRB application, Kratz says.

How will you exchange information?

Pouncey, Kratz, and **Tom Davis**, PharmD, chief executive officer and president of Odyssey Research Services, a site management group in Bismarck, ND, offer these suggestions for clinical trial sites to consider when drafting a disaster plan:

- **Anticipate major communication problems.**

As the aftermath of Hurricane Katrina showed, communication can be a profound problem following a disaster. The only way Kratz and his staff could communicate, since most telephones, cell phones, and Internet access were down, was through text messages, Kratz says.

"All communications networks related to the city weren't functioning. So if you had a New Orleans area code the communication was extremely unreliable and calling those numbers was very difficult for a number of weeks," Kratz recalls. "But we could send text messages to people on cell phones."

Meantime, the university's buildings in New Orleans were flooded on the first floors and the servers located there were inaccessible. Nonetheless, the university set up an emergency web site with rudimentary capability, Kratz says.

"We have e-mail service finally re-established in rudimentary fashion after three weeks, and that was a big hurdle," Kratz says. "After four weeks we could dial 504 area code numbers."

It took several weeks for the university to find adequate space for the research office, Kratz says.

"The most frustrating thing is that in one of these situations everybody is spread out all over the country," Kratz says. "So when I was able to establish some communication over the Internet and by telephone, we put up notices on the emergency web site, asking investigators to contact me with regard to the status of their projects."

It's a good idea to establish a voice mail system with out-of-state service prior to, or immediately after, the disaster, Pouncey suggests.

"I think that's part of the planning process, deciding how to communicate with employees post-disaster," Pouncey says.

Staff can use the voice mail number to let sites know where they are located and how they can be reached, and the same toll-free number can be given to subjects and patients, she says.

Another communication strategy is to designate prior to the disaster, when it is possible, where employees will meet in the event that all telephone and Internet communication is impossible, Pouncey says.

When a hurricane or storm knocks out power and telephone service, but does not impact road travel, this strategy gives everyone an opportunity to meet and discuss in person the next steps they will take.

Likewise, trial sites should find out in advance where each employee plans to go during the evacuation and what their contact information will be, Pouncey adds.

It's important to communicate frequently with staff and allow employees to talk about what happened to them, Pouncey says.

"We held a teleconference staff meeting three to four weeks after the storm," Pouncey says. "I was communicating with people daily, whenever they could get to me and to them."

At the teleconference, staff shared their new addresses, described their living arrangements, and provided contact information, she says.

"It's some level of comfort to re-establish communication with peers and colleagues," Pouncey says. "A week after the storm I was [evacuated] to a daycare center, and someone sent me their time sheet from last week."

Odyssey doesn't have a back-up answering service in the event of blizzards because the company has never had a telephone service disruption, Davis says.

"We have locations in Asia, South America, and China—all connected," Davis says. "We use an IP phone system over the Internet, and we can connect with Argentina by dialing four digits, so if Odyssey's phone lines go down, we still have the ability to have some communication with the rest of our sites."

• **Make data and supply protection a priority.**

Clinical research organizations have large numbers of samples and massive amounts of data on site, Pouncey notes.

"At a Phase I site, you might be the only site and study, so if you lose that data, you lose the entire trial," Pouncey says. "But if you lose data from five or 10 sites out of 500, it won't have the severe impact it would have had in a phase I study."

One phase I facility in New Orleans had samples on site and wasn't able to move them before the hurricane, she recalls. "But they maintained those samples via generator and even risked life and limb to get them out after the disaster, when they retrieved them on dry ice and shipped them to a second location," Pouncey says.

A clinical trial site could have data backed up at a secure server off-site, but the site would have to make provisions for secure access and privacy considerations, Pouncey says.

"All the sites we currently work with appear to have paper data intact, some because the records were stored on the second floor," Pouncey says. "We have not been able to determine the status of their electronic records."

However, the supplies that were kept on site during the hurricane posed a problem, she says. "None of the sponsors will allow a drug sitting there during the storm to be used," Pouncey says.

"A number of sites are doing studies with controlled substances, and when you have a disaster with the mayhem of New Orleans, do you want controlled substances sitting there in a facility?" Pouncey says. "They may be in lock and key, but what kind of challenges do these present to a site?"

Since the supplies on site were unusable, clinical trial staff have to manually reorder supplies and explain the situation to suppliers, Pouncey adds.

The IRB files at Louisiana State University Health Sciences Center were converted to a new software system last January, and so they were using a version of the program that was housed on a server in New York, Kratz says.

"We've been accessing all IRB information over the Internet, and that's been extremely helpful for us," Kratz says. "We were able to get the PIs' names and contacts."

If the institution starts a clinical trials office, part of it would include having a management software package that could act as a repository of subject information, and this could be housed in another state, Kratz notes.

Odyssey's computer systems are located in various locations and are constantly backing up each other, Davis says.

"If one is flooded out, the other should be OK," he says. "And we have a calling tree for notification of individuals who need to be called if there's a system problem."

Emergency action plan for CROs

1. Make basic preparations.

a. Designate emergency management personnel.

b. Make first aid kits, flashlights, and fire extinguishers available.

c. Train personnel in first aid and use of fire extinguishers, location of utility switches and valves, and emergency action plan.

d. Store a current back-up copy of all electronic records offsite.

e. Store a copy of the EAP in multiple secure offsite locations.

f. Store a list of personnel and contact information in multiple secure offsite locations, including backup contact information such as family members.

g. Store contact information for study subjects in multiple secure offsite locations, including backup contact information such as family members.

h. Identify rendezvous locations.

2. Develop detailed plans for specific types of emergencies.

a. Identify potential emergencies (e.g., fire, flood, earthquake), and develop separate EAP for each type of emergency.

b. Identify points of vulnerability (e.g., records storage, computers, telephone communications) and develop separate EAP for protecting each point of vulnerability.

c. Identify scenarios (e.g., where a fire starts or when a water pipe breaks); fine tune EAP accordingly.

d. Allocate preparation resources based on the severity and likelihood of damages to each point of vulnerability in each type of emergency in each scenario.

The full plan is available online at: http://www.firstclinical.com/ resources/ journal.html.

Source: Norman M. Goldfarb, First Clinical Research, Palo Alto, CA.

Also, the company has access to institutions that have generators so if there is a prolonged power outage, company officials can make arrangements to have their supplies and samples at those locations, protecting them from being ruined, Davis says.

• Consider privacy issues when storing data and contacting subjects.

In the event of a disaster as devastating as Hurricane Katrina, some privacy practices and rules seem inconsequential.

For example, a cancer center at Louisiana State University had a large patient database on a server located in a downtown building. After the hurricane, the staff couldn't obtain access to the server, Kratz says.

"What this may argue strongly for is that at least in our situation we might want to think about having a large central repository of information and have it housed on a server someplace else," Kratz says.

"I've always been reluctant to suggest this because of privacy issues and the potential for compromising the privacy of individuals, but this experience argues strongly that we might want to go in that direction."

A lot of people might say that if all data were electronic then the problems associated with the recent hurricanes wouldn't happen, Pouncey says. But sponsors shy away from discussing storage of patient identifiers, largely because of HIPAA, Pouncey says.

Before Hurricane Katrina, no one was forced to think about how sites would communicate with subjects after a disaster, Pouncey explains.

Now it's important for sites to include this in their disaster plan.

For example, one strategy might be to post a message on the weather channel, prior to a hurricane or blizzard, that asks subjects to contact a clinical trial site as soon as they can after the storm, Pouncey suggests.

Then if the power goes out, sites could place radio ads, because many people will have battery-operated radios, she says.

The operating principle should be to do the right thing, putting subjects' safety ahead of regulatory privacy issues, Pouncey says.

"These are individual people who were giving to us by providing their bodies for us to observe, and HIPAA is there for their protection," Pouncey explains. "But let's protect that individual body in this situation, which might be more important than protecting their identity." ■

Compliance Corner

Quality assurance is a necessary component

Here are tips for a QA template

Everyone in the clinical trial industry wants to catch their own mistakes and omissions before a regulatory agency does, but the problem is finding the most efficient way to do this.

One model would be to have a research or clinical trial resource office provide quality assurance assistance and protocols, as well as education and training, suggests **Pamela DeWeese**, MAT, CCRP, administrative director of the clinical trials program at Indiana University Department of Medicine in Indianapolis.

"The important thing to remember is this is all for the good of human subjects research," DeWeese says. "The good of patients depends on us doing good work, so a logical place to start is to look at one's own vulnerabilities."

For instance, sites that rely on a number of industry-sponsored studies probably will not need to focus on these trials because they already are being monitored by sponsors, DeWeese notes.

"On the other hand, you have investigator-initiated protocols that are generated internally, and there's no external body coming in to check for those errors and omissions, so that may be an area of vulnerability," DeWeese says.

DeWeese offers these tips for starting a quality assurance program:

1. Decide how thorough audits will be.

"It's probably not realistic to check 100% of every patient on every study," DeWeese says.

Clinical trial sites will need a good representative sample that will let them know if they're on the right track, DeWeese explains.

This sample might be a policy to review records from 10% of new enrollees on investigator-initiated studies each quarter, she says.

Other decisions to make include:

- Which records will be reviewed?
- At what frequency (i.e., monthly, quarterly, annually) will the records be reviewed?
- What tools will be needed for the review process?
- What key issues will be assessed during the review?
- If there are problems, how much more information will the auditor seek?

The audits likely will include a look at documentation, particularly with IRB forms, adverse events information, and informed consent, DeWeese says.

"The auditor will need to look at source documents and what was put in case report forms," she explains. "The auditor is looking at actual data."

But the bigger answers an auditor will seek involve whether the clinical trial staff are adhering to the protocol and doing what they said they'd do, DeWeese says.

This can be determined by using consistent audit points, including:

- Did the site use the right version of the informed consent document?
- Did subjects receive the consent before treatment began?
- What are the trends regarding informed consent?

"You may not have to look at all 50 patients," DeWeese explains. "But if you've audited five, and three of those were using the wrong version of the informed consent form, that may indicate that the trial needs more thorough auditing."

2. Provide education and training assistance.

At the Indiana University School of Medicine, each department is free to select their own education method and requirements, DeWeese says.

"Our research compliance education offers some research training, and we've tried to be a primary source of clinical research training on campus," DeWeese says. "Education and training are another form of quality assurance."

For example, there is a three-day training program for research coordinators, and it's offered twice a year, DeWeese says.

"A couple of years ago the training program became mandatory for any new research coordinator with less than two years' experience at our institution," DeWeese says.

Items covered in the program include:

- history of drug development;
- regulatory issues;
- good clinical practice, IRBs and IRB forms, serious adverse event reporting;
- budgets and contracts;
- how to talk with patients;
- consenting subjects; and
- surviving audits.

"We recently added a behavioral side for sites doing quality of life surveys," DeWeese says.

"It's a pretty intense three days," DeWeese notes. "For some folks it may be the most thorough orientation and training they ever get."

The education also is structured in a way that might ensure better understanding, DeWeese adds. "We try to not just present the regulations, which can be pretty boring," DeWeese says. "We try to bring in people who help interpret regulations for our environment, looking at how to implement a study at Indiana University."

The idea is to make the information as concrete as possible so research coordinators will know how to apply the knowledge at their university trial site, she adds.

Aside from the three-day orientation, there is ad hoc training whenever important new regulations emerge, DeWeese says.

"Sometimes the education sessions are intense, and sometimes they include light topics, such as how to use the computer to manage documents," DeWeese explains.

The education and training are offered to each department, and the three-day sessions are limited to 35 people, she adds.

3. Focus on instruction, not punishment.

"I think of myself as an educator at heart, and we approach our internal quality improvement and assurance programs as an educational experience, rather than a punitive experience," DeWeese says.

When a study is audited, the study's staff are provided with help with writing a corrective action plan, DeWeese notes.

"We always do it with a flavor of how this is an educational experience, and we're here to help you understand what's going on," DeWeese says.

The idea is for trial staff to feel as though they can better take care of problems that arise and that if they have any questions or issues, they will know who to call for advice, she says.

"Stuff happens," DeWeese says. "You can make an error and omit something, and you just want to fix it and not have it happen again."

Often a quality assurance auditing program involves having people audit themselves or their peers, so it's important to do it within an atmosphere of professionalism and collegiality, she says.

"What we're trying to do is protect patients and provide self-improvement," DeWeese explains. "With that kind of philosophy, people are more willing to engage in activity that would otherwise seem more negative." ■

Special Report: SoCRA Conference Coverage

How to obtain fully informed consent

Start with knowing the patient's knowledge

*[**Editor's note:** This issue of* Clinical Trials Administrator *contains a story about how research sites can work toward obtaining fully informed consent. This is a continuation of the special coverage that began in last month's issue of the 14th annual Society of Clinical Research Associates (SoCRA) Conference, held Sept. 23-25, in Lake Buena Vista, FL.]*

Through education and better strategies in discussing research with subjects, clinical trial sites can improve their informed consent process, two experts advise.

One of the most important things a clinical trial site should do in obtaining informed consent is to assess the patient's knowledge about research and clinical trials, an expert suggests.

"How do patients perceive their disease, and how do they perceive what they've already learned?" says **Lyndon V. Evans**, CCRP, RN, research manager with CancerCenters of the Carolinas in Greenville, SC. Evans spoke about obtaining informed consent at the SoCRA Conference.

"Frequently, we want to make sure that they've opened their eyes, and they're perceiving their disease correctly," Evans says.

For example, a clinical trial coordinator might want to ask the patient in a breast cancer study whether she has ever had any experience with cancer before or whether she has any relatives who've had cancer, Evans suggests.

This is because many patients with adjuvant breast treatment have a good prognosis, but these same patients might fear the worse if their only experience with cancer was a grandmother who died from pancreatic cancer, Evans explains.

"So you want to help them see how it will be different, and you have to clarify those misconceptions," Evans says.

"One of the strategies we have is we have a seminar that we give applicants about working toward fully informed consent," says **John Wright**, BS, CCRC, IRB administrator at Baylor College of Medicine in Houston.

Wright had been scheduled to speak about informed consent at the SoCRA Conference, but due to circumstances beyond his control he was unable to attend.

"The seminar's agenda typically is an over-view of informed consent regulations, and we talk about special populations as they relate to informed consent, and we talk about quality improvement and the consent monitor process," Wright says. "And we go through informed consent scenarios where we ask for audience participation."

The seminar is offered to all principal investigators, research coordinators, and any staff who will obtain informed consent, Wright adds.

Think of the patient first

Evans and Wright offer these additional guidelines for obtaining full informed consent:

• **Make the environment comfortable and understand the standard of care.** "Think about the room you're in and the environment," Evans says.

For instance, bright fluorescent lighting might make people uncomfortable, and it's not a good idea to speak with patients while standing because the interaction should be on equal ground, Evans says.

Also, patients should be encouraged to have a family member or friend with them during the consent process so someone else will hear what is discussed, Evans says.

"The third thing is for the research staff and nurses to be knowledgeable about the standard of care, including what the physician will offer the patient off the protocol, because that's what the consent process is," Evans says. "How is the standard-of-care treatment going to be different vs. being on a protocol?"

For example, with cancer treatment the physician will most likely offer the standard of care if the patient chooses to not go into the protocol, Evans adds.

"So we need to know how the investigational treatment will be different and how it will affect them vs. the standard of care, and in most consent forms that's covered," Evans says. "We try to talk with the physician before consenting the patient to make sure we know what the other options are for the patient."

Once a clinical trial coordinator has covered the basics of standard of care, assessing the environment and patient's comfort level, and understands the patient's misconceptions about their disease and research, then it's time to talk about what the research is all about, Evans says.

Have a process in place

• **Develop a consent monitoring process.** "We encourage principal investigators to develop an internal consent monitoring program which they can do with members of their team," Wright says. "Also, the IRB may ask a particular investigator to have a consent monitor be part of the informed consent process."

PIs should have a rapport with subjects and present informed consent information in a way that encourages subjects to speak up and ask questions or express concerns, Wright says.

"This process needs to go on not only at the first encounter and screening, but throughout the duration of the research subjects' participation in that setting," Wright says.

Informed consent monitoring could involve someone from research compliance services or the IRB office, Wright suggests.

"The steps we would take is to have the investigator or informed consent designee or study nurse go through the informed consent dialogue with the potential informed consent subject," Wright explains. "Then the second step would be for the informed consent designee to leave the room and have the consent monitor enter the room, and that consent monitor would use a tool we have developed called the informed consent monitor form."

The monitoring tool is used as a guide for monitoring what took place during the informed consent conversation, and it has 16 questions, Wright says.

"The discussion between the monitor and research subject is respectful, and it's intended to see if the subject is conversant in the information contained in the consent form they just read and signed," Wright says. "It's intended to demonstrate whether the subject can locate certain key information within the consent form."

For example, some questions are as follows:

— Will you benefit from the study and, if so, how?

— If you decide to not participate or if you withdraw from the study what are your treatment options?

— Why do you want to be in the study?

— Do you have a copy of the consent form?

— Do you have any questions about the research study?

Subjects should be able to have the consent form in hand and be able to guide themselves to locate the answers, Wright notes.

"The consent monitor would jot down notes that the subject found the benefits of the study or were able to tell what the benefits were," Wright says. If the subject asks questions, these are recorded on the tool, Wright adds.

"The next step would be that the monitor documents this conversation and provides the information to the researcher or consent designee who obtained informed consent," Wright says. "It's a tool to give feedback to the investigator."

So the monitor might inform the PI that there were some parts of the informed consent process that were not understood very well by the subject and these need to be repeated or cleared up by answering additional questions, Wright says.

Provide background information

• **Provide context for human subjects research.** Often it's helpful to put the research process into historical context for patients, Evans says.

"If you're knowledgeable about the history of trials that led up to the one that you're conducting now, it gives patients a good sense of learning about the benefits of participating in a clinical trial," Evans says.

For example, if a patient at CancerCenters of the Carolinas had a lumpectomy and is considering enrolling in a clinical trial of a new chemotherapy agent, Evans can tell her that she was able to have her lumpectomy instead of a mastectomy because of clinical trials in the late 1980's.

"I tell her what we learned in the past in research that has improved her treatment," Evans adds. "You think about how brave those women were who were randomized to one surgical procedure to another, and this provides a historical timeline for patients."

Also, while it's not necessary to bring up the subject of research controversies, it's not a bad idea to use the term "guinea pig" to give a patient the chance to vocalize any misgivings, Evans says.

"I just say, 'Do you think it seems like you're a guinea pig?' and if they say, 'Yes,' then that's a lead into historical trials," Evans explains. "So I say, 'Yes,' in a sense they're a guinea pig, but look at what we've learned from research."

This approach breaks the tension and gives the patient permission to be open about his or her feelings and concerns, Evans notes.

Sometimes, clinical trial staff will encounter subjects who know about the Tuskegee trials and their tragic abuse of human subjects, Evans says.

"We had a prostate cancer prevention trial and were encouraging having African American men enroll," Evans says.

"The people who enrolled knew about Tuskegee and the tragedy of how African Americans were treated in that trial, so I found when we had information sessions on the prostate cancer prevention trial that we needed to mention it."

Keep the process ongoing

• **Have a follow-up strategy.** "We tell investigators and personnel attending a trial to keep in mind that subjects' participation is voluntary and make sure subjects speak up if they have any questions," Wright says.

"We encourage them to foster that rapport and that environment where subjects will feel comfortable about asking a question during the study."

It's important to stress that informed consent is a process of communication and dialogue and not just a form to sign, Wright adds.

"Make sure you follow up with people and encourage them to come back in with questions," Evans suggests. "One important thing is to assess their understanding by having them verbalize to you that they understand the protocol and treatment options."

One way to handle this is to say: "I understand you've talked with Dr. Smith about your treatment options. Please explain to me what your options are," Evans says.

"At all meetings with subjects they're reminded they're on a trial and can drop out," Evans says. "Frequently, we have to re-consent when new information is available."

Sometimes the re-consent is handled with a letter and other times the patient is called, she says. "Often they have to sign a whole new consent document with new information," Evans says.

"The investigator and physician are responsible for consenting the patient, but the research staff work in tandem with the physician and follow up and go through the process again," Evans says. "In one sense the research staff is a delegate of the physician." ■

Strengthen stem cell research ethics now

Protect safety of clinical trial participants

The possibility of using embryonic stem cells to treat disease, a strategy known as regenerative medicine, is not yet being explored in clinical trials, but current ethical practices need to be strengthened — now — in preparation for this possibility, according to an advisory committee at the University of California at San Francisco (UCSF).

UCSF's Campus Advisory Committee on Human Gamete, Embryo, and Stem Cell Research reports that current practices must be amended to promote both the safety and well-being of the patients who would participate in clinical trials and the confidentiality of people who donate the embryos, oocytes, and sperm that contribute to the development of embryonic stem cells.

The recommendations of the team, which includes leading stem cell scientists, are aimed at ensuring the safety of biological materials being donated for the development of human embryonic stem cell lines, protecting the privacy of the people who donate biomaterials, and promoting effective communication between clinician–researchers and patients about the nature of early stage, or Phase I, clinical trials.

Addressing these issues would require:

- seeking consent from donors of biological materials to allow scientists to recontact them over the years to update their medical records and rescreen them;
- implementing stringent measures to secure donors' confidentiality;
- fully informed consent.

Donated biological materials hold the key to enabling scientists to develop human embryonic stem cell (hESC) lines. However, transplanted hESCs and the proteins they produce could carry infectious diseases, such as Creutzfeldt–Jakob disease, and genetic-based diseases such as cancer or Parkinson's.

The FDA issued regulations in May 2005 for screening and testing for communicable diseases at the time of donation and for tracking transplanted materials back to the original donors. However, the UCSF team says that these regulations are insufficient.

It is critical, they say, that the consent process include asking donors to agree to be recontacted in the months or years following their donations, to provide updates on their medical history and participate, if necessary, in further screenings.

Reestablishing contact is necessary, the team says, for determining if diseases that could have been latent at the time of donation subsequently emerged. The process would allow scientists to determine if a donor has developed a disease with a strong genetic component that could affect the safety of transplanted cells. Notably, one embryonic stem cell line could be used to treat hundreds or thousands of patients. Thus, one cell line containing a pathogen or disease-causing genetic mutation could affect many patients.

Without permission to recontact and possibly rescreen donors, the team writes, scientists would be invading donors' privacy by recontacting them. In such circumstances, the donors might refuse to share updated medical information, which would disqualify the cells for transplantation.

It is equally critical, the UCSF team writes, that stringent measures be implemented to ensure that donors' medical records are secured. The authors advocate steps ranging from having computer files locked in a secure room and password-protected, with access limited; to having files with identifiers copy-protected and double-encrypted with one of the keys held by a high-ranking institutional official who is not involved in stem cell research; to having the records protected from subpoena by obtaining a federal Certificate of Confidentiality.

Finally, researchers should ensure that subjects are fully counseled and able to give a truly informed consent. Informed consent would include informing subjects that their therapy would involve the use of cells obtained from embryos and making clear that Phase I clinical trials are intended to begin the process of determining the safety of a given therapy and the appropriate dosage; such trials rarely lead to improvement in the patient's condition. ■

COMING IN FUTURE MONTHS

■ Cooperative research groups provide benefits to sites, subjects

An update on global training issues

Spreadsheet format helps with trial budgeting

Try the five-level evaluation of clinical research training

CE/CME Objectives / Instructions

The CE/CME objectives for *Clinical Trials Administrator* are to help physicians and nurses be able to:

- **review** pertinent regulatory mandates;
- **develop** practical clinical trial oversight strategies;
- **review** best practices shared by facilities that successfully conduct clinical trials.

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.

Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material.

After completing this activity at the end of each semester, you must complete the evaluation form provided and return it in the reply envelope provided to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CE/CME questions

21. Which of the following is not a basic strategy to include in an emergency action or disaster plan?
A. Identify rendezvous locations.
B. Store a current back up copy of all electronic records offsite.
C. Store a list of personnel and contact information in multiple secure offsite locations, including backup contact information such as family members.
D. All of the above should be included in an emergency action plan.

22. When establishing an internal audit process for clinical trials, which of the following is NOT a good question to consider?
A. Who will be permitted from the clinical trial site to witness the audit?
B. Which records will be reviewed?
C. At what frequency (i.e., monthly, quarterly, annually) will the records be reviewed?
D. What key issues will be assessed during the review?

23. When an informed consent monitoring process is performed, which of the following questions should be asked of subjects?
A. Do you have any religious beliefs that might prohibit your participation in research?
B. If you decide to not participate or if you withdraw from the study what are your treatment options?
C. Did you understand what the research nurse said about risks and benefits?
D. All of the above

24. In the event of a major disaster, which of the following problems might most severely impact a clinical trial site?
A. Communication problems, data retrieval, and storage of supplies and samples
B. Privacy concerns when contacting subjects and retrieving data
C. Staff evacuations out of state
D. None of the above

Answers: 21. D; 22. A; 23. B; 24. A

2005 SALARY SURVEY RESULTS

CLINICAL TRIALS ADMINISTRATOR

An essential resource for managers of clinical trials

Turnover continues to be an issue for industry

Long hours, lack of job security contribute to turnover rates

The good news for clinical trial administrators is that salaries remain fairly high and most reported receiving at least a small raise in the past year, according to the 2005 C*linical Trials Administrator* salary survey.

According to survey results, about 92% of respondents have incomes above $50,000 a year. About 22% reported earning between $60,000 and $69,999; nearly 19% said they earn between $70,000 and $79,999; 11% earn $80,000 to $80,999, while about 19% earn $90,000 or more per year.

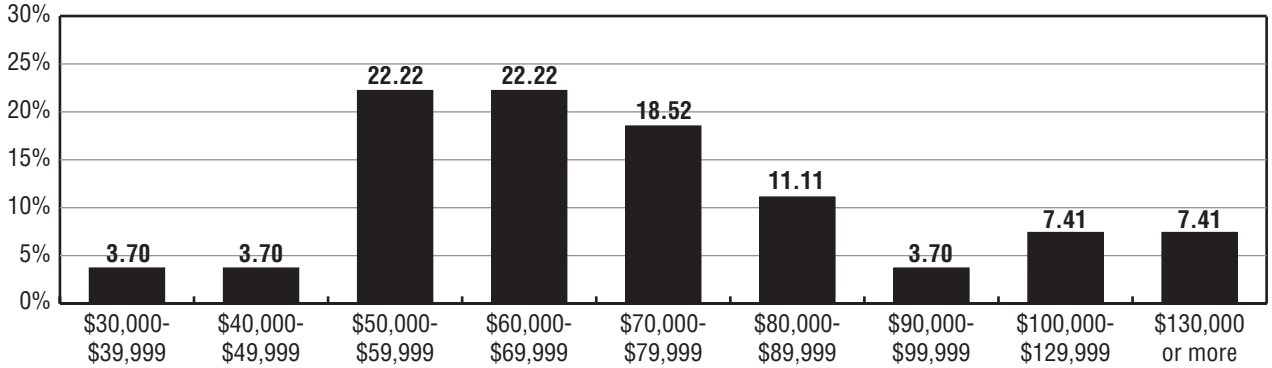
Among those who responded to the survey, 11% said that their salary decreased in the past year while 26% said their salary has not changed, and 63% reported an increase. Salary increases, according to the survey, ranged from 1% to 6% for 52%; almost 4% received an increase of 7% to 10%; and a little over 7% received increase in the 11% to 15% range.

While a little more than half of the sites responding to the survey reported no change in their department's staffing, one third said their department added staff, and about one-sixth said their department lost staff in the past year.

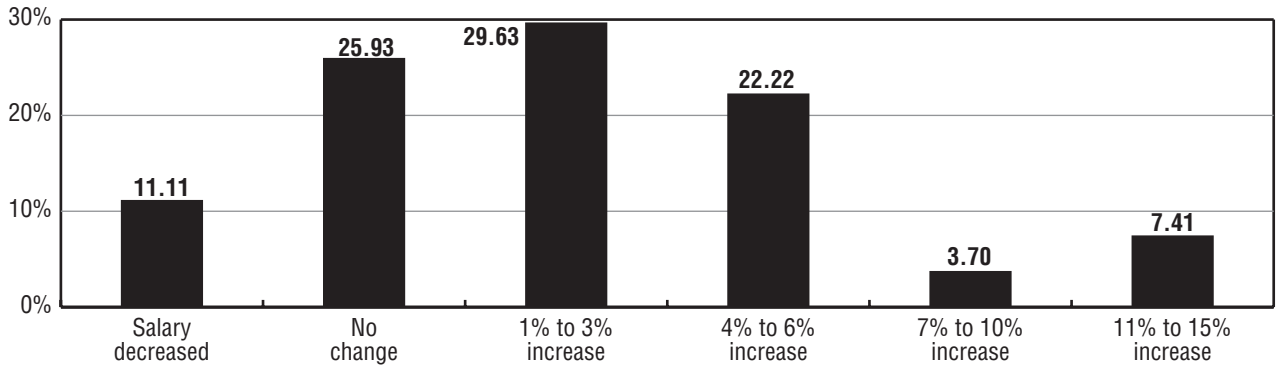
Long hours common

Clinical trial coordinators and staff generally are employed full-time and often work long hours. According to the salary survey, about 19% of respondents work between 31 and 40 hours per week; 66% stated that they work between 41 and

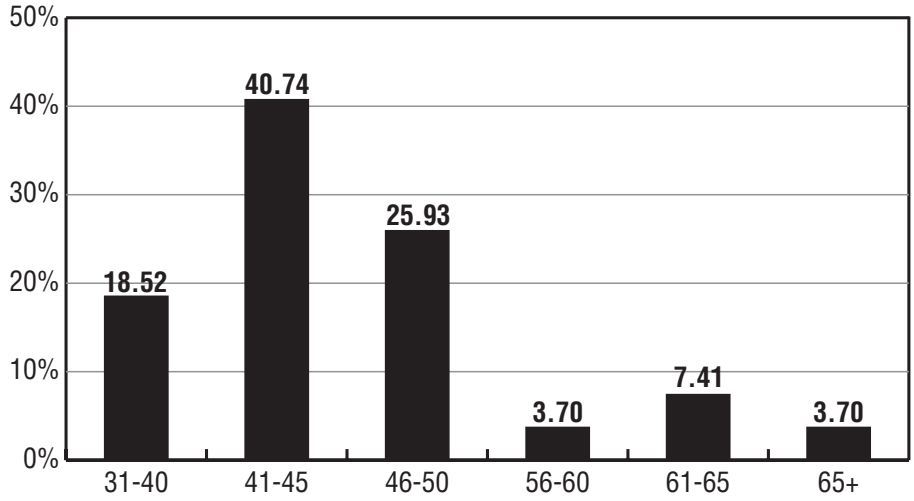
What is your annual gross income?



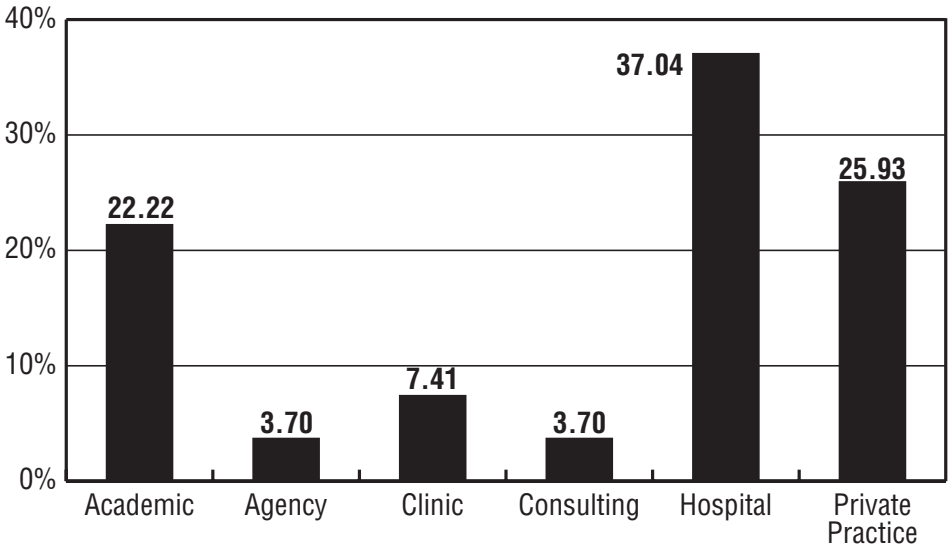
In the last year, how has your salary changed?

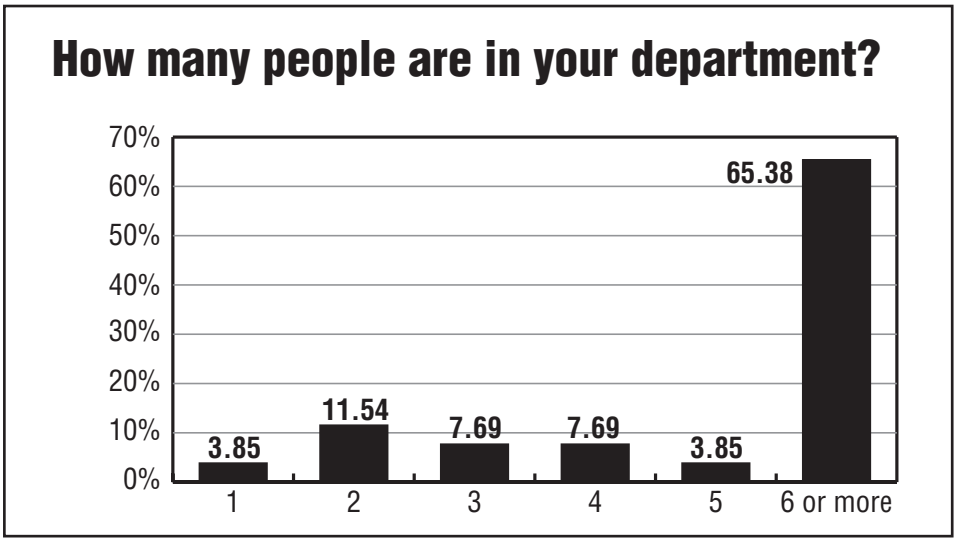


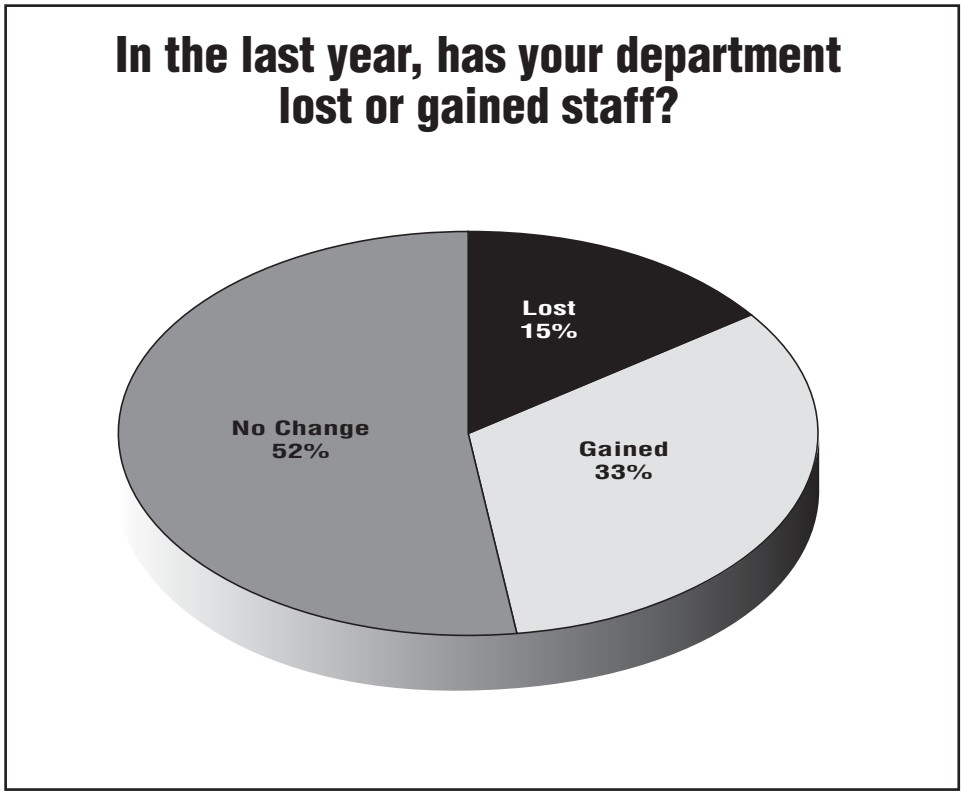
How many hours per week do you work?



What is the work environment of your employer?







50 hours, and about 15% of respondents said they work 56 or more hours per week.

Survey respondents also have a great deal of experience. More than a third have between four and six years experience; nearly one in five have between seven and nine years experience; and close to 40% have spent 10 or more years working in the field.

All the respondents indicated that they are highly experienced health care professionals as well. Ninety percent reported 10 or more years experience in health care in general, and 37% stated that they have been involved in health care for 25 or more years.

Retention is a challenge

Like many businesses, clinical trial sites typically have busy and slow times, so a key challenge facing managers is how to retain good employees when the work isn't there for several months at a time.

"We do a lot of federally funded trials, and when we have grants like that we find it's a little bit more difficult to retain staff because of the volatility of the work. And we have budgetary problems, and I'm having to cut staff because I don't have the means to keep the number we would need," says **Tamara Dowd Owens**, RN, MSN, MBA. Owens is a clinical research manager of the Governor's Institute on Alcohol and Substance Abuse in Research Triangle Park, NC, and an editorial board member for *Clinical Trials Administrator.*

Diversify your resume

Even when clinical trial site managers know that more grants will be coming in soon and they know that in the long run it costs more to let experienced staff go and then hire new, untrained employees, it's difficult to find the money to bridge those slow stretches, Owens notes.

"When you look at your expenses and cash flow sheets it can be daunting," Owens says. "We want to retain people, so we have discussed putting staff on other projects that may not be research related, so they could maintain their salaries.

For example, perhaps a willing clinical trial coordinator could work temporarily in the finance department, learning new skills until more clinical trials are available, Owens says. "There are some staff who say, 'All I know how to do is research,' but they need to be flexible, and it helps to diversify their resume," she says. "It makes them more marketable in the long run."

The clinical trial coordinator who spends some time working with a financial analyst on the budget or with a grant writer will have skills that future employers would find very attractive, and it will help secure their current position during slow times, Owens notes.

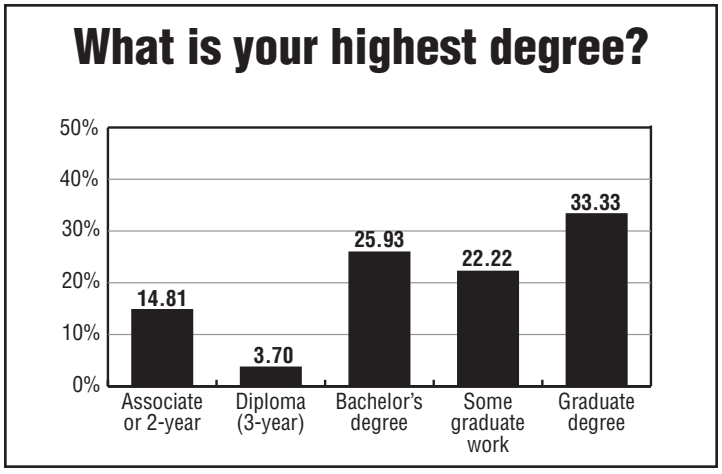
"We've got one of our medical studies that's ending, and we're hoping another study comes our way, but meantime, I've transitioned one of our study coordinators on a mental health grant that doesn't include seeing patients," Owens says.

"It's a data analysis type of study, but she's not had the opportunity to do that before, and she's very willing to do so because she wants to stay here."

From the clinical research coordinator's perspective, turnover often is due to work loads and time commitment problems says **Deborah Rosenfelder**, RN, BSN, CCRC, clinical research coordinator at the University of Pittsburgh. Most of the time clinical trial staff leave to move to jobs in other research areas or industries, Rosenfelder says.

Sites that would like to reduce turnover should have a better understanding of time commitment in coordination of a study and probably should improve education, Rosenfelder notes.

"Most of the coordinators that I work with are very dedicated and committed," Rosenfelder says. "I do not think the industry comprehends the amount of layers coordinators now need to go through to get a study up and running and what it takes to keep it going."



More training needed

Training, whether new employees are recent graduates or seasoned professionals, is always an issue, Owens says. "Your personnel need to be really focused on getting regulatory documents in order and always being prepared for a potential FDA audit," she says.

There's definitely a need for more training in the clinical trial industry, Rosenfelder says. "The more you understand the process, the better you are able to complete your job," she says.

Owens says she is big on education and believes there are many opportunities for furthering education and training when all of the industry's conferences are taken into account.

"I always encourage people to pick one conference a year to go to," Owens says. "With the regulations changing, it's always good to stay abreast."

Certification is another way for clinical trial staff to keep up with education, skills, and training. However, while certification is a good idea for clinical trial coordinators, it doesn't always receive the recognition it deserves, Rosenfelder says. "There's a [time] commitment to obtaining it and keeping it up," she says. "Most coordinators work far above the assigned hours now." ■

CLINICAL TRIALS ADMINISTRATOR

An essential resource for managers of clinical trials

2005 Index

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