IRB ADVISOR

Your Practical Guide To Institutional Review Board Management

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IN THIS ISSUE

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Cultural differences raise consent issues in multinational research

IC must translate not just language, but concepts to different culture

As more institutions become involved in international research, informed consent becomes a more difficult process.

While emphasis often is put on the linguistic challenges of consent — creating a document that correctly outlines the details of the study in multiple languages — there are cultural translation issues as well. What one culture means by "consent," "risk," or even "research" may be very different from how another culture interprets those concepts.

Vincanne Adams, PhD, a professor of medical anthropology at the University of California, San Francisco, says it's important that IRBs understand the potential for these types of cultural translational issues and to be prepared to deal with them.

As an example, she points to a project she became involved with in 2000, an effort to collaborate with health officials in China and Tibet on a randomized clinical trial comparing the benefits of a traditional Tibetan drug with a biomedical drug to control postpartum hemorrhage.

In the process, she says, the team sought to help Tibetans set up their own infrastructure for conducting research using standards acceptable to the international health community.

And along the way, Adams says her group has encountered challenges in cultural translation, as well as in educating their IRBs about the differences between Tibetan medical culture and their own.

"We had to negotiate with them," she says of her efforts to facilitate even the earliest stages of the project with her own IRB. "It just took months and months and months to process it all and convince the committee — they were receptive to it — to go through the process of spelling it all out and explaining.

"They were not obstructive, they're just a bureaucratic institution," Adams says. "They didn't want to stop the project; they just wanted to make sure that we were meeting ethical standards. And so it just takes a lot of work."

Creating an IRB

The team of clinicians, researchers, and medical anthropologists began collaborating with physicians and public health professionals in Lhasa, the capital of the Tibet Autonomous Region (TAR), one of the least developed regions of China. The TAR has its own medical schools for both biomedicine and for traditional Tibetan medicine, which operates on principles that involve balancing three elements within a patient known as "humors": wind, bile and phlegm, and the physical elements of earth, fire, water, air, and space.

The team decided to look at the issue of postpartum hemorrhage because it is a significant risk to new mothers, who often give birth at home without medical help.

The project was set up to compare a Tibetan medicine called *zhi byed bcu gcig* 11 (ZB11) to the Western drug misoprostol, which has similar indications, risks, and benefits.

First, however, the group had to create the necessary research infrastructure, setting up a research committee with the Chinese government and with contacts at the three hospitals in Lhasa and at the traditional Tibetan Medical College. That committee set up a three-phase project, beginning with a feasibility study, then a study comparing ZB11 to first a placebo and then to misoprostol. Each phase would require IRB approval not just in the United States, but in the home country, according to guidelines set up by the National Institutes of Health, which was funding the study, Adams says.

"It delayed our project by a year and a half to two years," she says. "Anytime you're working in a foreign country, to create a system that's based on a requirement of the U.S. government is a very tricky thing, especially in a country like China."

But during that lengthy process, she says, there was an opportunity to do a very thorough exploration of cross-cultural informed consent. She outlined the process in a paper published recently in the journal *Culture, Medicine and Psychiatry*.[1]

Linguistic challenges

Adams, who has been working in Asia for more than 20 years, says that with a process of this complexity — in this case including contributors in the United States, China, and Tibet — there is always a linguistic challenge. All the documents had to be translated into English, Chinese, and Tibetan, as did the training programs for those associated with the research project.

In general, Tibetan health providers were trained in Chinese, the language of their own biomedical training. However, to speak with

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participants, who generally spoke only Tibetan, it was necessary to find translators fluent in all three languages, a difficult task.

Beyond language issues, Adams says the Tibetan culture posed unique challenges to the traditional Western ideas of research. In Tibet, most research historically had been conducted by physicians on their own patients, mixing their own medicines and observing the results. Even today in medical institutions, control groups and standardized protocols are not the norm.

Some research concepts were particularly tricky to negotiate, involving long explanations to Tibetan researchers and participants — and flexibility on the part of American IRBs that reviewed the informed consent process, she says:

• **Disclosing risk.** In early ethnographic interviews, Adams' team learned that Tibetans rarely discuss the potential risks of a medical intervention, because they believe that if a patient envisions himself experiencing harm, it could agitate the wind humor, causing a harmful outcome.

"The concern was that we would basically create a negative environment and a perception of fear among our participants that was unnecessary," she says.

Trying to balance Western obligations to disclose risk with Tibetan concerns led them to present only the most critical information, eliminating details about the risks of delivery in general, or descriptions of hemorrhage.

They stated in the informed consent that all women bleed during delivery, and if a woman seemed to be bleeding excessively, she would be treated at the hospital.

• **Randomization.** Adams says there's no direct translation for the concept of randomization in the Tibetan language, and that many Tibetans understand "chance" differently than Westerners, believing that past actions, or even past lives may have an effect on present outcomes.

"Our IRB at one point wrote back that we should use flipping a coin as an example," she says, noting that that action has no cultural significance in Tibet. "They were trying to be helpful but they didn't have any understanding of the cross-cultural context."

To try to get the point across, ethnographers referred to a traditional Tibetan practice of drawing lots to distribute resources throughout a community. It's more complex than a coin flip but does involve a certain amount of randomization.

The pilot informed consent document stated: "This process is similar to the Tibetan system of drawing lots, or *gyan gyab*. But unlike *gyan gyab*, you will not know which group you are in. Only the doctors will know."

• **Placebo.** Tibetan medicine holds that the so-called "placebo effect" is a necessary component of good medical treatment — that using the right words or attitude will help a medicine be more successful. In addition, all substances are thought to be either potentially helpful or harmful, making it difficult to explain the role of a placebo in a controlled trial. In fact, there has only recently been a Tibetan term for placebo, and it translates literally as "mind-healing drug," which could raise potential problems for IRB review since it suggests that the drug has healing properties.

In the end, they referred to a pill that "has no medical effect but is made to look just like ZB11."

Throughout this process, there were lengthy negotiations with the IRBs in the United States, some of whom had not wrestled with these types of issues before, Adams says.

"I think IRBs have a lot to learn," she says. "I think some institutions that have a large body of faculty who do international work are probably more prepared for this. I know our institution was not like that. They're very focused on research in the U.S. and it's a whole new thing to be doing these kinds of international work."

In her own case, she says she spent a lot of time talking to the staff in the IRB office and writing lengthy cover letters explaining the team's plans.

Adams says IRBs whose researchers are starting to delve into these areas should think carefully about how to bring cross-cultural expertise to their committees. She says her own IRB had an advantage because it included an anthropologist.

"I think recognizing a broader understanding of flexibility and how to accommodate different cultural understandings of risk and vulnerability, in ways that don't hamper the ability to do the research but augment it, would be great."

Reference

1. Adams V, Miller S, Craig S, et al. Informed consent in cross-cultural perspective: Clinical research in the Tibetan Autonomous Region, PRC. *Cult Med Psychiatry* 2007;31: 445-472.

Combination of consent documents may improve subjects' understanding

Participants get more reading simpler version first

When trying to explain a complicated clinical trial to participants, which approach is better: a jam-packed standard-issue informed consent document, or a lower reading level, more interactive model? And which would subjects prefer?

The answers would seem obvious, based on reams of studies that have looked for alternatives to the standard informed consent document. And indeed, as expected, a study by the Feinstein Institute for Medical Research in Manhasset, NY, showed that participants shown a simpler, innovative form were better able to comprehend the study than those shown the hospital's existing informed consent document.

However, the simpler form was not universally popular among the participants, particularly those who were shown it first. The findings may suggest that the best approach for informed consent isn't one document at all, but a combination of documents, says **Emmelyn Kim**, MA, assistant clinical analyst in Feinstein's Office of Research Compliance.

"When we asked people about it, they were telling us that they were able to understand the standard consent form after initially reading the innovative consent form," Kim says. "We think that maybe using simple brochures or study outlines might be helpful for these trials to help facilitate further understanding.

"Doing that prior to being given this really dense, really difficult consent form actually might help to reinforce the main components of the trial for people."

Kim's group gave a poster presentation about their study at the 2007 Annual Public Responsibility in Medicine & Research (PRIM&R) Human Research Protection Program Conference in Boston, Dec. 1-4, 2007.

Easier, but not shorter

Kim and **Kathleen McGill**, MPH, manager of research compliance in Feinstein's Office of Research Compliance, say their study of an innovative consent form evolved from a workgroup on informed consent held at their institution.

To test a new type of form, they created a consent form for a Phase 2 study of a fictional cancer drug, first using the standard template. Then, they incorporated suggestions from other studies aimed at improving comprehension of consent in designing their innovative form:

• **Simpler language.** The institution's standard informed consent template is written at a 12th grade reading level, Kim says. For the innovative form, they were able to bring the language down to an 8th grade level, although the process wasn't an easy one.

"It was actually hard doing that with our standard template," Kim says. "You have to sort of step outside the box and test it with lay people and see if they can understand what you're trying to do.

"It was challenging. But I think it's really crucial, especially for researchers who want to recruit very diverse populations in their research trials who may not be at the 12th grade reading level."

• **Enhanced readability.** In addition to simpler language, the workgroup changed the format of the document, incorporating more white space, larger fonts, and lots of bullet points.

The headings are written in a question format: "Why is this study being done?" "Why might you want to be in this study?"

An information box in large colorful type warns participants: "Caution! Giving false or incomplete information about your medical history or the use of drugs or alcohol could affect your health while in this study."

The result is actually a longer document than the dense, small-font standard form, but a much more readable one, Kim says.

• **Opportunities for participant questions.** At the end of each section, a box is provided for participants to write their own questions about the study. In each box is an area for them to check off that the question was answered.

To compare how well the standard and innovative forms aided comprehension, the group recruited 37 volunteers, and split them into two groups.

One group read the standard form first, took a Quality of Informed Consent (QuIC) questionnaire on the information, and then reviewed the

innovative form to answer questions about which form they preferred. The second group did the opposite, beginning with the innovative form, taking the QuIC test, and then reviewing the standard form.

Interactive element improves understanding

The results showed that those reviewing the innovative form first scored higher on 11 of 13 knowledge areas within the test. In two key areas — experimental procedures and risks or discomforts — the results were significantly higher for the innovative group.

"I think those are key because they're main elements of the informed consent that people struggle with all the time," Kim says.

When asked which form they preferred, 100% of those randomized to the standard form preferred the innovative version. However, more than 60% of those randomized to the innovative form preferred the standard form.

McGill says that those reading the simpler format first may have been able to take that information into the higher reading level form and enhance their understanding.

In another surprising result, those who first viewed the standard form actually thought they knew more about the study than they did.

Kim and McGill say those who viewed the more complicated form may have missed opportunities to ask questions, even though they didn't understand. They think the use of question boxes in the innovative form may have helped increase understanding by prompting participants to consider whether they really understood the material.

Highly educated subjects

They note there are limitations to the study, due to its small sample size and the generally high education level of the participants — almost 40% had a master's degree, McGill says. The Rapid Estimate of Adult Literacy in Medicine test administered to the participants showed that most scored above the 9th grade level in medical literacy.

Still, McGill says it's worth noting that the group struggled with the consent forms, and had difficulty answering questions even though they were allowed to view the document while taking the QuIC.

"So here you have a very highly educated population, struggling with consent forms," she says.

Looking to continue innovation

The two hope to continue their study of this issue, seeking out a larger and more heterogeneous sample. They hope to accomplish that by getting funding that could allow them to offer incentives to reach a more diverse population.

And they hope others will build on their findings by doing research that involves employing more than one type of consent form to help the information sink in for participants.

"Maybe using patient brochures or simple consent handouts prior to giving them this lengthy consent form [would help improve comprehension]," Kim says.

Since the workgroup began studying this issue, Kim says there's been increased discussion about improving informed consent at Feinstein.

"I had a conversation with our administrator the other day about perhaps having this [innovative consent] template on-line for people to consider using," she says. "We know of one group that's already using a similar type of innovative consent format. I don't know how their participants are responding, but I know people are actively trying to change their forms to increase understanding."

The two say their study reinforces the often-repeated principle that informed consent is not a document, but a process.

"The form is an important part of it, to provide the participants with information," Kim says. "But I also feel it's important to allow a supportive and positive environment for questions to be asked," pointing to the question box that was included in the innovative form.

"That way, participants can come up with questions on their own and not be intimidated. And that might be key to really stimulating discussion about the project itself." ■

Protecting uninsured participants in research

How will subjects be treated if something goes wrong?

Nearly 47 million Americans lack health insurance, leaving them without regular access to health care — and making them a

potentially vulnerable population in health care research.

From the possibility of undue influence to how to deal with research-related injuries, uninsured subjects raise ethical issues that IRBs must consider when reviewing protocols, says **Daniel Vasgird**, PhD, CIP, director of research compliance services for the University of Nebraska-Lincoln.

Vasgird says the Belmont Principles of beneficence and justice underlie IRBs' responsibility to subjects who lack ready access to health care.

"You have a moral obligation there to make sure that the individual would benefit from the specific study — that it's not just something that you can rationalize out and say you're doing it for the greater benefit of mankind," Vasgird says.

According to the U.S. Census, 15.8% of all Americans reported being uninsured during 2006, the highest percentage since 1998. For some groups, the percentages are even higher: 20% of African-Americans and 34% of Hispanics reported being uninsured during 2006.

Important subject pool

In his previous position as chair of the IRB at the New York City Department of Health, Vasgird saw many uninsured patients.

He says the department was an inviting place for researchers, particularly during the 1990s, when the HIV epidemic was in full swing and tuberculosis cases were on the rise.

"The department has well over 100 clinics scattered throughout the city, with tens of thousands of people receiving treatment in those clinics — STD clinics, tuberculosis clinics, and the like," Vasgird says. "Researchers want to have access to that subject pool, so the Department of Health IRB is an important one."

He says his interest in uninsured research subjects was piqued by a study his IRB reviewed that sought to look at the effectiveness of quinolones, a class of powerful antibiotics.

"An individual had gotten funding from a pharmaceutical company and wanted to use the tuberculosis and STD clinics to recruit subjects," Vasgird says. "Some of [the quinolones] have some very extreme side effects, and as I was reading through the protocol and consent form, I realized after I got to the end, that there was no provision made if anybody was injured, or if they had serious side effects."

Vasgird says he consulted physicians on his board, who all advised that the IRB should require the sponsor to provide free medical care or compensation if subjects were injured in the course of the study.

But the researcher balked at the idea, pointing out that the federal regulations require only that participants be told whether health care is available, not that it be mandated.

"In other words, all you have to do is let people know that they're not going to be cared for if something goes wrong — it's a very, very minimal standard," Vasgird says. "We told him yes, we're aware of that, but I pointed out to him that the IRB can raise the bar, if they feel it's ethically necessary to do it. In this case, we felt it was ethically necessary."

Ultimately, Vasgird says, the researcher and sponsor agreed to the provision and the study went forward.

He says an IRB faced with a study that presents more than minimal risk to subjects should take similar steps to ensure that uninsured subjects are protected in case something goes wrong.

Not every study deserves such stringent requirements, Vasgird says. He says it's up to IRBs to do the risk-benefit analysis and decide whether it's necessary.

"If the risk is low, then in those kinds of cases, you don't have to stipulate it," he says. "You don't have to make a federal case out of every single study. But the board should have that stipulation within its portfolio — it should be ready to say that you have to do this when it's pretty obvious that the physical risk is relatively high."

He notes that in some cases, health care for those injured in research is paid for through the institution's liability insurance.

"So my first word of advice to any IRB is to double-check with your general counsel to make sure that you don't have those provisions in place in an insurance policy."

Other ethical issues

Beyond concerns about research-related injury, the inclusion of uninsured subjects poses other ethical challenges, Vasgird says:

- **Undue influence.** Vasgird says some uninsured subjects may be signing up for clinical trials because they are trying to receive health care and medication that they can't get elsewhere.

"Their income levels are modest at best," he

says. "So they're more susceptible to coercion. It's possible that people would be making a decision to be involved in a study that they normally wouldn't do. They're not thinking seriously about what it could mean for them down the line in terms of their well-being."

He says IRBs should be alert to that possibility when reviewing protocols that are likely to recruit a large number of uninsured patients.

• **Post-trial benefits.** Vasgird says vulnerable groups such as uninsured patients shouldn't be expected to contribute to research that can't benefit them later, if they're unable to access the study drug because of lack of health insurance.

It's a concept that applies not only to uninsured subjects in this country, but increasingly, to research subjects in developing countries.

"If at all possible, you're supposed to provide so the individual can receive care," he says. "Certainly from the standpoint of the developing countries, they want to make sure that the medical care and other things are going to be provided after the people leave."

Vasgird says that IRBs that routinely deal with uninsured subjects should take special care to involve representatives from that community on the board.

"You should try to make a point of not just having somebody unaffiliated," he says. "You should be going beyond that to find individuals who can really be representatives for these particular groups — a minister, a social worker, a principal, or teacher who comes from that community and who can speak for them." ■

Study offers insight into how subjects feel about standard IC language

Rights section earns many negative comments

IRBs that desire to improve their informed consent (IC) forms might learn a great deal from questions and comments from people reviewing these forms.

One of the largest studies to look at participants' opinions of a mock IC form reveals many negative impressions of some of the more common language and sections.

"We don't have anything from our data that would allow us to say what should or should not be in an informed consent form, but what's clear is there are some very negative reactions and confusion to the section on rights and confidentiality," says **Kevin Weinfurt**, PhD, an associate professor of psychiatry and psychology at Duke University in Durham, NC. The research was presented at the 2007 Annual Public Responsibility In Medicine & Research (PRIM&R) Human Research Protection Programs Conference.

The researchers developed a six-page, mock IC form, with standard language used in IC forms at Duke University. It's similar to the language used at other academic research institutions. It was based on a hypothetical study with a hypothetical sponsor company, and 470 participants were interviewed about their impressions.

"Several study coordinators at Duke University were involved in the development of the consent form," Weinfurt says. "So we had a lot of input and tried to make this as realistic as possible in all respects."

The people participating in the trial had ample time to look over the IC form, and the mock IC form was reviewed by the IRB chair.

"When participants were recruited, they were verbally consented and then sent the real consent document for this study," says **Alice Fortune-Greeley**, BA, a research assistant at Duke Clinical Research Institute of Duke University Medical Center in Durham.

The mock IC form was watermarked and printed in yellow so participants could see the difference between it and the real IC form they signed, she notes.

"It looked like a consent document other than the watermark that said 'Pretend ICD,' marked in yellow," Fortune-Greeley says.

"We gave participants a chance to look over the informed consent documents before we talked about it with them, and this is standard," Fortune-Greeley says.

"Then we went over the informed consent document section by section, which also is standard," she adds. "This was done over the telephone and face-to-face."

Most negative feedback to participants' rights

The section of the IC form that received the most negative feedback involved participants'

rights in the study. It received one positive comment, 45 negative comments, and 15 comments in which the participant said he or she would hesitate to participate, Fortune-Greeley says.

"We asked participants if they understood each part of the document and what was the likelihood that they'd participate in the study, using a scale from one to five," Fortune-Greeley says.

When investigators used a multivariable model to compare the negative comments in each section with the reported likelihood to participate, they found that the sections involving rights, confidentiality, and financial disclosure were uniquely associated with the reported likelihood of participating in the study, she explains.

"So if people made negative comments in those sections, they reported a lower likelihood to participate," Fortune-Greeley says.

Legalese = ill at ease

Several participants commented that the rights section of the form seemed like legal mumble jumble, Fortune-Greeley says.

"Some participants expressed the feeling that it was something written by lawyers," Fortune-Greeley adds.

Investigators created a mock IC document, using standard language from Duke University. They made sure the form was realistic and had it broken into six sections, including an introduction, comments about how the study worked, risks to participants, benefits to participants, financial disclosure comments and questions, and confidentiality and subject's rights, Fortune-Greeley says.

"The primary issue in the 'Your rights' section was we had a statement in the informed consent document that's standard for many research projects, saying that the university medical center is not responsible for payments for injury," she explains.

Participants made comments after each section, and this particular section elicited these types of comments:

- "Why can't the university medical center pay for my treatment?"
- "How long will they pay for my treatment if I'm injured as a result of this study?"
- "That's the section where I'd have concerns if I read it because it looks like they're not guaranteeing they'll keep you whole if something happens."
- "I'd be hesitant to participate. Anyone would be crazy to get into a study if they said 'What we're going to do is harm you, but we won't give you any help if it happens.'"

Most of the negative comments regarding this section focused on the lack of payments for an injury and the lack of long-term health insurance in the case of an injury, Fortune-Greeley notes.

The mock IC form's rights and confidentiality section is very similar to what actual clinical trial participants will find when reading informed consent forms.

"These contain legal language that institutions put in the documents for their own protection," Weinfurt says. "Our data should encourage institutions to reconsider why they are putting those kinds of statements in the consent documents and whether they want to continue to do so."

For instance, in the mock consent form, researchers included language that says the study team will try to keep the study records confidential as much as is possible, but there can be no guarantee of absolute confidentiality of the study records, says **Chantelle Hardy**, BA, a research assistant with the Duke Clinical Research Institute in Durham, NC.

"So we received a lot of questions about why there was no guarantee of absolute confidentiality of study records," Hardy says.

Participants asked these sorts of questions:

- "Why isn't there a 100% guarantee?"
- "Who outside of the hypothetical medical center would see the patient's records?"
- "Why would the study sponsor need to see their entire records?"
- "Would names be sent out outside the university medical center?"

"And there were more questions about how data are collected and stored," Hardy says. "But only nine participants actually stated they'd be hesitant to participate because of the confidentiality section."

Overall there were 40 negative comments about the confidentiality disclosure, which indicates this section was important to some people, Weinfurt says.

"Many people have done studies where they asked people specific questions about whether this section bothered them," he notes. "But we provided a mock consent process and only recorded instances where participants

volunteered something spontaneously and said, "This doesn't sound right; I have a problem with this.'"

When 40 people out of 470 have such strong negative feelings about a section that they will interrupt the interview to say something about it, then that is significant, Weinfurt says.

Use data to facilitate consent process

The study is the largest one conducted that uses the mock consent method, Weinfurt notes.

"The size of the study allowed us for the first time to record the spontaneous reactions of patients to a consent process," Weinfurt says. "For all of us involved in this study, and that includes the chair of the IRB, this was seen as an opportunity to evaluate the practices here at Duke."

In fact, the IRB chair at Duke is enthusiastic about presenting the data to the IRB and using the information to reassess consent language, Weinfurt says.

"We are very excited about that, and we can see it will have some impact on the way we do research here at Duke," Weinfurt says. "It's our hope it will get other people thinking along similar lines."

With a study this large, the data collected will show how common it is for people to have certain perceptions of IC document language.

"I think our data will help prepare study coordinators in facilitating the consent process and in anticipating the types of concerns that come up," Weinfurt says. "It may not be that 75 percent of people will have trouble with the confidentiality section, and maybe the way it's worded in most documents will stay that way for a while, but the study coordinator can at least know the types of questions people have."

So the research will inform study coordinators and IRBs and help them find ways to assist study participants in making better decisions, Weinfurt adds.

"For the confidentiality section and the 'Your rights' section, I think we're aware that the content is determined in part by federal policy with regard to HIPAA and the larger institutional legal policies," Weinfurt says. "So while the IRB may want to change what's in there, they may not be able to do so immediately."

Still, it's Weinfurt's hope that the research will give IRBs an opportunity to try changing the language. ■

Best Practices Report: Improve orientation, training

[Editor's note: This is the first of an occasional series on best practices in the IRB world. This issue of IRB Advisor *will focus on how to develop a successful orientation and training program for new IRB members. In the March issue, there will be a second perspective on this same topic.]*

Institution provides IRB members with thorough, ongoing training/education

IRB's program is notable best practices

IRB offices no longer can use the trial-by-fire method of new board member training.

For today's IRB, which often deals with a variety of research topics and expects a great deal of regulatory and scientific knowledge from members, a thorough orientation and training program is necessary.

Duke University in Durham, NC, has a comprehensive training and continuing education program for IRB members. The program was improved after the research institution expanded from having one to having eight IRBs. The expansion has occurred in the nine years since the former Office for Protection of Research Risks (now the Office of Human Research Protection), suspended all federally funded research at Duke until "serious deficiencies" were corrected.

"As the IRBs grew, the membership grew, and we had fewer experienced members to help train new members, so it was obvious we needed to do a little more training," says **Charlotte Coley**, MACT, CIP, director of the IRB education programs at Duke University Medical Center.

For the first few years after the expansion, Coley would have an orientation meeting with new IRB members, providing them with checklists to use for reviewing protocols and showing them how things were done at Duke.

Goal to prepare for primary review

Then Coley met with one the IRBs' vice chairs

and asked him to help develop a mentoring program for new members. The program would focus on how to be a primary reviewer.

They piloted the mentoring program. It was a success and has been implemented for all of the IRBs, Coley says.

The basic orientation component works this way:

• First, new members observe a meeting, but don't vote.

• For the second meeting, the new members shadow the vice chair and prepare the primary reviewer checklist. "This is a dry run as if they were going to present the protocol themselves, but they don't," Coley explains.

• "They meet in the hour before the meeting to discuss with the vice chairs any questions they have about the process or the protocol," Coley says.

• At the second meeting, the new IRB members will vote, and at the third meeting they are on their own, Coley adds.

"But they always have the vice chair to call as their ongoing mentor," Coley says. "They spend time with the vice chair, develop a relationship, and know that the vice chair is willing and able to answer any questions they have down the road."

Extended program for community members

This process is enhanced with community members.

Community members who are not affiliated with the university and who are not medical doctors are given the opportunity to shadow the vice chair multiple times until both they and the vice chair feel they are ready to do a primary review on their own, Coley says.

"We have some community members who are retired PhDs, and they can do most any study," Coley says. "We have some engineers, some retired public health professors."

For community members who are not scientifically trained, the IRB will assign them the less challenging protocols, including straightforward renewals and amendments, she adds.

Expanded training for all members

The IRB has also expanded its continuing training and education for all IRB members. Coley provides this look at the additional training sessions:

• **Develop monthly meetings for community members.** "I have a series of monthly presentations for community IRB members," Coley says. "I start out with the background of human subjects research and information on why there are IRBs and what the responsibilities are for IRBs."

One session will cover informed consent. For this program, Coley will show IRB members a clip from the HBO movie, "Miss Evers' Boys," which is about the Tuskegee syphilis study.

"My favorite clip from that study is where the public health doctors have all the subjects in a room in a semi-circle, and they explain in scientific terms what the Tuskegee study is all about," Coley says. "And Miss Evers asked if she could speak with the men, and she starts explaining in lay terms, and you could see a change in their body language, which makes it obvious that now they understand, while before they were being polite."

Coley invites speakers to the monthly meetings, including another IRB member who is a pharmacist and is on the faculty of the university's school of nursing. He does a presentation on different styles of research and research studies.

Another speaker talks about data safety monitoring boards (DSMBs), and other sessions have focused on HIPAA and privacy issues.

The meetings last two hours, and some research coordinators also attend them, Coley notes.

These meetings are especially helpful to the IRB's non-scientist members, who represent several members of each 16-18-member board, Coley says.

"We have mathematicians, engineers, a retired film critic, a retired chairman of the department of statistics," Coley says.

Since there are so many non-scientists on each board, no one need feel intimidated or afraid to ask a question at an IRB meeting, she notes.

"I encourage them to ask questions at IRB meetings," Coley says. "They can participate and make very good points, seeing things that sometimes those of us who are much closer to the research don't see."

Community members enrich an IRB's meeting deliberations, but the additional training is important, Coley adds.

Coley repeats the monthly sessions annually, so if members have missed it the first time, they can hear it later.

Each meeting includes a continental breakfast and free parking, which are the only incentives

offered to the IRB members to attend the training sessions, Coley says.

• **Educate at meetings and workshops.** "We also have 10-15 minute brief educational sessions at each IRB meeting," Coley says.

These sessions are kept short so that the IRB members have time to review protocols and vote, but they can provide updates on regulatory changes and issues that arise during IRB meetings.

Another educational forum that's useful is the half-day workshop for IRB members only.

"We bring in outside speakers, like Robert Levine of Yale University, who has been a keynote speaker," Coley says. "He's a well-known researcher and ethicist who attended Duke as an undergraduate."

Duke faculty also speak on the various topics covered at the workshops.

"We're going to do a workshop in January on the informed consent process," Coley says. "We'll cover the IRB's responsibility and what to note in reviewing protocols."

The workshops, which include breakfast and snacks, typically are held once a year and they're attended by IRB chairs and members at Duke, as well as IRB members from other local IRBs, Coley says.

"We use a hall that has 172 seats, and we generally fill that," Coley says. "This is another way to pay back our members and thank them for their service."

The institution also sends IRB members to national conferences where they might receive additional training, Coley says.

"This strengthens and improves their abilities as IRB members, and it also brings back value to the departments they serve in as more knowledgeable human subjects protections people," Coley says.

• **Offer special education and training for medical students.** Since the third year of medical school is devoted to research, Duke medical students can conduct the research anywhere around the world, Coley says.

For those who decide to stay in Durham, there is an option to serve on the IRB, attending as if they were regular IRB members, she says.

These third-year medical students have to apply to be an IRB member, saying why they want to be a member. This is in addition to their research project.

"So I do a two-hour orientation for them about the IRB and regulations," Coley says.

The medical students also receive mentoring from the vice chair as they see first-hand how human subjects research is viewed from the perspective of IRB members.

CE/CME Objectives

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

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

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

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 letter of credit. When your evaluation is received, a letter of credit will be mailed to you.

COMING IN FUTURE MONTHS

- Working with the NCICIRB: The role of local IRBs
- University develops written Internet research guideline
- Here's what was learned from IRB reviews of HIV vaccine trials
- College students weigh-in on research of Internet social networks

"We think it's wonderful when we get medical students in combined degree programs, working on their PhDs," Coley says. "We had one student who was getting a PhD in philosophy, and so he was an active IRB member for five years, and now he's back as a medical student, completing his medical degree."

There typically are two to four medical students each year, although this year there are seven medical students and several more who have stayed on the IRB after completing one year of service, she says. ■

CE/CME *questions*

5. Which statement is true about a study that compared a standard informed consent document to an innovative, simpler form?
   A. The standard form led to better comprehension.
   B. The simpler form was universally preferred among the subjects.
   C. Those exposed first to the standard form thought they knew more about the study than they did.
   D. None of the above

6. Federal regulations require that the sponsor of a clinical trial provide compensation to any subject injured in the course of a study.
   A. True
   B. False

7. In a large study of a mock informed consent form, which standard IC section caused participants to make the most negative comments?
   A. The description of the hypothetical trial
   B. The hypothetical risks and benefits section
   C. The rights and confidentiality section
   D. The description of hypothetical clinic visits and lab draws

8. In building an IRB member mentoring program, which of the following orientation/mentoring components might work best?
   A. Have new members first observe an IRB meeting, but without voting.
   B. At the second meeting, have new members shadow the vice chair and prepare the primary reviewer checklist as a dry run.
   C. New members vote at the second meeting and are on their own at the third meeting.
   D. All of the above

Answers: 5. (c), 6. (b), 7. (c), 8. (d).