IRBs contribute to study delays, but there are many other factors

Here are key strategies to reduce delay

The clinical trial industry continues to experience major delays, leading to higher costs and a slow pipeline of products making it to market, experts say. A slow IRB review process at many institutions can contribute to this problem.

In 2005, the IRB review and approval process ranked fourth in the most commonly listed cause of trial delays, says Norman M. Goldfarb, managing director of First Clinical Research of Palo Alto, CA, and editor of the Journal of Clinical Research Best Practices. Goldfarb also is the chairman of the Model Agreement Group Initiative and chairman of the Clinical Research Relief Fund.

The cause of delays most commonly listed were contract and budgets, which ranked first; enrollment and recruitment, which ranked second; and protocol amendment and refinement, which ranked third, Goldfarb says.

IRB review and approval, which is rated fourth, is followed by consent form review and approval in fifth place. Together, these are clearly significant in their impact on study delays, Goldfarb says.

"The primary problem is a cultural conflict between the objective of getting research done in a business-like manner and, number two, doing everything possible at all costs to protect the subjects," Goldfarb explains. "A number of research sites with local IRBs haven't been able to reconcile those two conflicting goals."

Another reason for delayed IRB reviews is that some local IRBs still operate in a way that worked well in past decades, but doesn't suit the current research environment, suggests Paul W. Goebel, Jr, CIP, president of Paul W. Goebel Consulting Inc. of Monrovia, MD. Goebel is on the editorial advisory board of IRB Advisor.

"They have not committed the resources necessary," Goebel says. "Some local IRBs have not increased their staff for many years while volume of work has been steadily increasing."

Meantime, the record-keeping burden has increased, and regulatory creep has set in, Goebel says.

"It's not really in the regulations, but there are new things the IRBs have been asked to do," Goebel says.
For instance, Goebel recently saw on an IRB Internet message board that some IRB members believed the regulations required them to look at a study’s budget.

“I don’t think that’s true, but that’s an example of what is happening,” Goebel says. “If it’s said enough times, people will think it’s true.”

The Office of Human Research Protection (OHRP) has begun to focus on helping IRBs find ways to increase efficiency and reduce delays.

While it could be argued that OHRP shouldn’t be in the business of helping pharmaceutical companies get drugs to market faster, it also could be said that improved efficiency could lead to better quality and greater consistency in IRB reviews, the experts say.

“I think the OHRP’s focus is a useful exercise,” says Alan M. Sugar, MD, chairman of the New England Institutional Review Board in Wellesley, MA. Sugar also is a professor of medicine at the Boston University School of Medicine in Boston, MA, and he’s the director of Infectious Disease Clinical Services at Cape Cod Hospital in Hyannis, MA. Sugar also is on the editorial advisory board of IRB Advisor.

“You make the process faster by making it more robust and focusing on the important aspects of what the IRB is meant to do, rather than simply focusing on making sure the words on a form are accurate,” Sugar says.

Sugar, Goebel, and Goldfarb offer the following suggestions for ways to improve IRB response time, while maintaining or improving quality of protocol reviews:

1. Run a local or institutional IRB more professionally, like an independent IRB.

“There are a lot of unnecessary delays,” Goldfarb says. “You could do the review more quickly without sacrificing quality review. And you might even improve quality by doing it quickly because IRB members won’t forget what they talked about at the last meeting.”

For-profit businesses improve their revenue and profit by being expeditious, so for-profit and independent IRBs typically have frequent meetings, sometimes more than once a week, Goldfarb explains.

“One of the largest sources of delays of IRB review is time between meetings,” he says. “So if meetings are held every week, there are fewer delays than if they’re held every month.”

IRBs that meet monthly take, on average, 10 days prior to a meeting and 10 days after a meeting to handle a protocol, so that adds 20 days to the monthly 30-day cycle, Goldfarb says.

When protocols require a change, this will add another 40-plus days to the process, he adds.

Many local IRBs once would shut down for the summer and not have meetings in July or August, the months when the academic institution’s staff were on vacation, so some reviews would be delayed for several months, Goebel notes.

While this practice has largely stopped, institutional IRBs still are not as fast at reviewing protocols as are independent and commercial IRBs, which often
can review a protocol within one week, Goebel says.

“One week is about as good as you can do with a quality review, and it takes a lot of resources to do that,” Goebel says. “Local IRBs often have turnaround times of a month.”

The New England IRB meets weekly, so it’s able to respond fairly quickly to protocol submissions and changes, Sugar says.

“The big challenge is to get consistency among IRBs,” Sugar says. “One of the problems we have is that IRBs are not consistent with one another; every IRB has its own way of doing things and is not always consistent within it, and that can drive investigators crazy and contribute to prolonged review times.”

Some academic IRBs contract with independent IRBs to review studies by commercial sponsors in order to help meet their turnaround time, Goebel notes.

This is a good idea particularly for IRBs that meet monthly at institutions that would like to increase research, Goldfarb says.

Also, local IRBs sometimes have to devote considerable time and resources to the review of protocols created by academic researchers because these studies often are complicated and have not been vetted by staff, as have protocols written by commercial sponsors, Goebel says.

“Investigator studies at academic institutions are the hardest to review and take the most time,” Goebel says. “You can’t compare the turnaround time with those studies with the turnaround time of a study prepared by a commercial sponsor.”

**2. Invest in IRB staff to prevent some common protocol problems and causes of delay.**

While smaller local IRBs have a very small staff, some of the commercial IRBs have a staff of about 80 people, and they meet three times a week, which makes it much easier to review protocols within a week, Goebel says.

Still, institutions with small IRBs could invest in technological resources, such as software to automate the submission process, to reduce paperwork and improve workflow, Goldfarb suggests.

This would free IRB staff time for other activities, such as working with investigators to improve their protocol submissions.

“What happens quite often is the IRB will send something back to the clinical investigator who will take two months to respond to the IRB, so you can’t fault the IRB for that delay,” Goebel says.

However, an IRB administrator could pre-review protocols, Sugar says.

“In a lot of academic institutions, you have to fill out a protocol submission form to summarize what’s going on, and that can be quickly reviewed

---

**Letter to the Editor**

*What message is being sent to IRBs when focus is on streamlining reviews*

Dear Editor:

I read this article (“Sharing of IRB approvals raises questions, concerns.” - October, 2006, IRB Advisor) with growing concern for the message it sends for streamlining the IRB review process to be able to “reduce delay” and satisfy “concerned investigators” and “sponsors who want to get their investigational product more quickly to market” and the “unnecessary burden” of multiple IRB reviews. This is scary thinking when you consider the IRB process was developed to protect subjects not to enhance the process of getting a new product or treatment to market. Given the data on the average timeline from R&D for the release of a new product to the market, can an “IRB review delay” adversely impact in any significant way? I worry that we have listened to the complaints with the current system but have not appropriately sorted the sources of the complaints and the motivations.

Have we dug into the complaints as deeply as necessary to accurately evaluate them? For example, what is the formula for measuring “IRB review delays”? When does the clock start to tick — from the very first efforts of the investigative team to package the protocol for IRB review or when the package is submitted, determined complete and accepted for review by the IRB? Lack of knowledge of institutional requirements for submission and limited research experience are two issues that come to mind that can greatly delay the submission and ultimate review by an IRB. Because of the many roles in research, the four issues raised above have multiple definitions. Thus are we careful when listening to complaints to sort through the verbiage and evaluate the accuracy of the complaint?

Lastly, as an IRB Administrator, I get concerned with a system offering solutions that run counter to the role of the IRB. Have we, as human subject protection specialists, lost our focus? Has our focus shifted to placating the industry side of research because of all the noise in the marketplace?

Signed:
Paulette M. Vandzura
IRB Administrator
by whoever does the intake,” Sugar explains.

One person who knows what the IRB does and which questions commonly arise, could pre-review protocols prior to the IRB meeting, Sugar says.

If the protocol has obvious questions that need to be answered, then the IRB administrator could notify the investigator and ask for these answers to be returned prior to the IRB meeting, he says.

“If we don’t have a protocol pre-review and if there is something missing, then we lose at least a week in the review process,” Sugar says.

Another way to prevent protocol problems would be for an IRB office to educate principal investigators about the proper ways to put together a protocol, Sugar adds.

“One thing that’s good about our IRB’s renewal and submission forms is that we’ve used them so long and have tweaked them, making them reasonably easy to fill out, so that if someone has serious difficulty filling out the form, it usually is an indication of other problems,” Sugar says. “If the renewal form is deficient in the information we ask for, then that gets our attention.”

3. Start IRB review at same time contract negotiation begins.

The clinical trial industry could reduce delays by investing a little extra funding in the process, Goldfarb says.

The contract and negotiation process now takes an average of four months, which means that much time is spent before the IRB review process can begin, Goldfarb explains.

“Ideally, you want to have the two processes go along side-by-side, so when one completes, the other will complete the same time or earlier,” Goldfarb says.

However, sites may be reluctant to start the IRB review process before the contract is signed because if the contract falls through, they have lost the time and money spent in the review process, he says.

“One way sponsors can alleviate this is to say, ‘If you go down both paths at the same time and don’t get a contract, then we’ll cover the extra costs,’ and some sponsors will do that,” Goldfarb says. “Others will not, but in general, sites don’t ask for it.”

These innovative practices work for some people and should be considered by others,” says Daniel Nelson, MS, CIP, an associate professor of social medicine and pediatrics at the University of North Carolina, Chapel Hill. Nelson has spoken about improving IRB office efficiencies at national human subjects protection conferences.

One mistake IRB directors often make is to err on the side of being overly strict in their interpretation of federal regulations, Nelson notes.

“IRBs should be making use of the flexibility regulations provide,” Nelson says. “I think it’s human nature to think that if a little bit is good, then a lot must be better.”

In fact, Nelson says he used to be in the camp of thinking that it’s better to err on the side of having more review in every case, but he now believes that’s not always true.

“For example, if an IRB always takes every action to the full IRB, even when it involves eligibility for expedited review or an exemption, or if they never give consideration to an alteration or waiver of consent or cooperative review arrangements, when circumstances might warrant these, the IRB is doing a disservice to research participants, research communities, and their own institutions,” Nelson says.

“Ultimately, it becomes a research issue, and the sheer weight of over-applying this in every circumstance puts bulk in the system, diverts attention, resources, money, time, and effort away from places that are truly value-added,” Nelson says. “We see more and more people now thinking a bit more critically at an administrative level, and it’s not always value added to take everything to the highest level of processing.”

The goal is to not shortchange important things, but to recognize that with limited resources, it’s not necessary to do everything to the extreme, Nelson adds.

With this goal in mind, Nelson makes the following suggestions for building greater efficiencies into the IRB process:

• Create checklist tool: “We increasingly see this as a helpful aid,” Nelson says.

“The regulations lay out eight criteria that must be satisfied before an IRB can approve a study,” Nelson says. “My experience is that many IRB members don’t approach each review with those firmly in mind, but approach it with what feels right in mind.”

Increasingly, IRBs are using checklists as their framework for a review, and these are helpful for guiding the discussion and ensuring consistency, Nelson says.

Build efficiencies into your IRB practice

Collect data about own practices

There are a number of innovative practices IRBs can employ to improve their office’s efficiency and work quality.
“These shouldn’t be used in a lock-step mentality to just check off things, but they are helpful,” he adds. With a checklist, an IRB can make sure its review is rigorous and less subjective, and it reminds IRB members of the most essential regulatory elements, Nelson says.

It also forces IRB members to be analytical in their protocol review, he says.

- Use evidence-based IRB practice: “A positive development that, increasingly, we’re looking for and expecting is evidence-based IRB practice,” Nelson says.

“By that I mean, it’s just like a medical practice that’s informed by data and experience,” he explains. “Obviously, we now have people asking more critical questions and gathering data to support questions like ‘How many IRBs do we need?’”

Other questions that can be asked as part of data gathering are:

- We only have one protocol per meeting, so are we meeting too often?
- Do our meetings run too long, and so should we split the board into two?
- How much staff are needed to properly handle the workload?
- Do all the consent form edits that IRBs typically require really improve understanding?

“This is an area where I think there’s been a lot of supposition and personal references and pet peeves,” Nelson says. “Everyone has their own consent form they look for, and there’s a growing body of literature that analyzes this in a more rigorous scientific manner to see what is value-added.”

The IRB field needs to be more analytical and critical about its own practices and processes, subjecting them to study, he adds.

“So much of IRB practice has been informed by a seat-of-the-pants feel,” Nelson says.

Individual IRBs could institute a best practice by simply tracking their own data about how long meetings are taking and how many protocols are being reviewed at each meeting, he suggests.

“How much staff will there be for each protocol action, and how many actions per full time equivalent is an even better way to say it?” he says.

IRBs increasingly are moving into the direction of collecting their own data and analyzing their own results for evidence-based best practices, he notes.

“For many years, I have had a bar chart that I add to each year to show our workload and the number of actions we’ve taken, and we update that annually and check the data as the year progresses to see how the workload is growing or shrinking,” Nelson says.

As more institutions collect their own data and share it with others through informal networking or formal quality improvement initiatives, it results in benchmarking data that will give IRBs an idea of what is working at other institutions.

Also, many IRB directors have reached out to peers to conduct an informal survey of their own practices, Nelson says.

- Seek accreditation: “Growing efforts like accreditation for programs and certification for individuals are in essence benchmarking efforts and are a positive evolution in the field,” Nelson says.

“These are built around best practices in the sense of how standards are set.”

National organizations set these standards and benchmarks that institutions and individuals can seek to achieve as a way of measuring their own performance, he says.

Accreditation and certification in the field are relatively new, but there has been an increase in the number of organizations and individuals who have sought to measure their own performances against these standards, he says.

“That has had a positive impact on the field as a whole,” Nelson says. “Until these came along, IRBs were left to kind of wondering to themselves about what is adequate and whether they are doing something right or wrong.”

---

IRB chair’s concerns had chilling effect on project

Important knowledge can be stymied

When investigators interviewed 22 children in 1992, the IRB had questions, but the project was approved, leading to one of the few studies conducted in its area of interest.

When investigators attempted to update this study more than a decade later and move toward using the resulting information to develop a pilot program, their experience was far different, recalls Joanne Riebschleger, PhD, MSW, an assistant professor of social work at Michigan State University in East Lansing, MI.

“We didn’t get very far with the project this time,” Riebschleger says.

Investigators could have pursued it, but their time was limited and there were other projects to consider, so this one was abandoned after their initial discouragement from the IRB, she notes.

So what was the project? “We wanted to interview
children of parents who have a serious mental illness,” Riebschleger says. “Basically, our claim is that there are a whole lot of them, and they’re very much an invisible population with significant needs for information about mental illness and for support.”

Specifically, the proposal called for interviewing children, ages six to 17.

“We knew that we were dealing with a number of protected classes, including women, people with mental illness, and children,” Riebschleger says. “I anticipated that it would be important to think about the risk and how we could minimize or ameliorate it and, hopefully, eliminate the risks.”

When the study was conducted in 1992, there were no problems resulting among the children and their parents, she recalls.

So Riebschleger spoke with the IRB chair from a large, East Coast university about the project and how the purpose was to ultimately develop a series of groups for the children in whom they could learn about mental illness and coping skills.

The problem the IRB chair identified had to do with rather the parents were competent to provide consent for their children to participate in the study, she says.

The IRB chair’s main question was: “Is the person diagnosed with a serious mental illness of such a sound mental state to give consent for their child to talk to someone about their life?” she says.

This shows how differently investigators and IRB members view certain research issues, particularly when it relates to social-behavioral research.

With 20 years of mental health field experience, Riebschleger knew that the vast majority of mentally ill people are competent and are perfectly typical parents and guardians.

Some mental illnesses are cyclical, but medication support helps people remain functional, she says.

“If people knew how many people they knew who were walking around with significant mental illnesses, they’d be really surprised,” Riebschleger says. “And these include people sitting on IRBs.”

From a mental health care perspective, the study would be well monitored with mental health services case managers and therapists assisting, she says.

“If a person was truly delusional, there would be a common sense element of the interviewer not interviewing the child of a person who was delusional,” Riebschleger adds. “The mental health staff would tell investigators if there were any problems.”

According to the IRB chair’s interpretation of regulations, investigators would have needed to put the parents of child participants through psychological testing to prove they were competent to give consent for their children to talk with investigators about mental illness, Riebschleger says.

“This did not make sense,” she says. “While I completely support the idea of human subjects review, particularly with the historical abuses of people with mental illness, when we’ve gotten to the point of protecting them so much that they can no longer consent for their children to participate in a study?”

Such an attitude amounts to presuming these parents are incompetent until proven competent, Riebschleger says.

The IRB chair also raised a concern about the parents becoming violent toward their children, she says.

“While any study involving children would need to consider how to deal with actual or suspected child abuse or neglect, this concern seemed to go beyond that in that there was almost an assumption of potential violence toward the child,” Riebschleger explains. “As the investigators in the study are mandatory reporters, it would be something you’d have to share up front with the parent and child.”

At this point, the IRB chair referred investigators to the Belmont Report, which they read, attending to the section about impaired persons.

“It referred to the very great need to make sure people with impairments were protected and not harmed in any way, or taken advantage of,” Riebschleger says. “But there also was a section about how to not suppress research that could help that population, if the benefit to risk ratio merited it.”

This confirmed for researchers that the intent of human subjects protection goes both ways: “It would be considered not okay to take away from people with impairments the right to have research done to improve their conditions,” Riebschleger says.

“In addition, there is within the mental health system a strong movement of consumer-oriented practice and client empowerment that would not put up with such a thing as this,” she says.

“So we thought about how we could educate the people who serve on IRB boards about the strengths of people with mental illness,” Riebschleger says. “We want to educate them that the vast majority of mentally ill people are not violent, unless they have a substance abuse disorder.”

Also, IRB members should take a look at the stereotypes to which they have been exposed, including the idea that mentally ill people are mad and bad, she says.

“If there’s a crime committed, the newspapers still typically report the mental health status of the
alleged perpetrator, but they do not report the substance use status,” Riebschleger says. “That’s only done because there’s an assumption by the general public that mental illness equals violence, and that’s not true.”

Meantime, researchers may neglect what mental health experts call the “invisible kids,” who have grown up with a parent who has a mental illness, Riebschleger says.

“The other piece of this is in social science research, it’s hard to show benefits,” she notes. “But I think there’s strong enough evidence that giving people information and giving children and teenagers information about mental illness when they’re living with someone who is mentally ill can have some benefits.”

Children often blame themselves for a parent’s mental illness, so an educational intervention would be of significant benefit, Riebschleger adds.

Since it’s clearly not in this population’s best interest to chill out research projects like this one, there may be a way to address an IRB’s concerns.

For example, investigators of similar research could add a section on parenting to the mental health agency form, which is used to conduct consumer planning. And the mental health professionals could advise parents that researchers would like to talk to the children about support for handling their daily activities, and if the parents said they did not object, this could be passive consent for the child interviews, Riebschleger explains.

Further, researchers could develop a safety monitoring plan in which the mental health staff communicates directly with the parent on child, monitoring for any unanticipated negative effects. Also, the interviews would begin with the oldest children, and outcomes would be reported to the IRB before interviews progressed to younger children, she adds.

Lessons from 9/11: Protecting subjects in disaster research

IRBs on the front line relate their experiences with research conducted after the attacks

In the days after the Sept. 11, 2001, terrorist attacks, New York City became a focal point for researchers interested in studying everything from post-traumatic stress disorder to physical complications among workers at the Ground Zero site.

After spending five years reviewing research proposals for these studies — and studying the results — IRB heads at New York City research institutions say we’ve learned much more about the risks to participants, and how to better protect them in similar research in the future.

One of the most important revelations, says Alan Fleischman, MD, chairman of the IRB at the New York Academy of Medicine, is that studying victims of trauma is not as risky to participants as IRBs may have feared.

“In the past, IRBs, not having any solid data or evidence or articles, tended to consider remembering of (traumatic) events as a retraumatization, and researchers have really debunked that notion,” Fleischman says.

“Reactivation of memories or some stress-related symptoms that may occur as one thinks about the trauma are very different from reliving the trauma,” he says. “I think that’s what we’re now seeing in much of the research that’s come post 9/11. It may well be that there is some emotional distress associated with research, but it is not at a level that perhaps IRB members or outsiders would have thought.”

Despite that fact, Fleischman says that research surrounding mass casualty events such as the Sept. 11 attacks does present some special challenges to IRBs, who might find themselves dealing with emotionally fragile people while operating in a chaotic, time-sensitive environment.

In an event of that kind, an IRB needs to be prepared to work quickly, he says.

“The New York Academy of Medicine IRB convened in emergency session, met with the investigators, developed guidelines, developed consent processes, developed checks and balances, all within three weeks post 9/11,” Fleischman says. “We did that because we thought it was a national disaster and a critically important thing to do. But we didn’t break any rules or regulations. We were very careful to fulfill all the regulations.”

In fact, he says, the academy’s IRB has actually taken steps to prepare in the event of a similar attack, by pre-approving research proposals contingent on another disaster. The IRB would not have to be convened to approve the research, but would check on it later to ensure it had been implemented as planned.

“There’s nothing in the regulations that says that’s not allowed,” Fleischman says. “We’re preparing so that the IRB isn’t a great limiting or obstructionist part of the process.”

Learning from Oklahoma City

Fleischman says that the New York Academy of Medicine IRB learned valuable lessons from the
1995 terrorist bombing of the Alfred P. Murrah Federal Building in Oklahoma City.

The academy contacted Oklahoma authorities in the days after the Sept. 11 attacks, after reviewing its own extensive library and finding little information about disaster-related research. Fleischman says it was only then that they learned about the extraordinary steps taken by then, Oklahoma Gov. Frank Keating, who directed that all research conducted with survivors of the bombing be reviewed by the University of Oklahoma’s IRB.

“They basically told all the victims’ families and those who had been hurt that they should only participate in those projects that had (the university IRB’s) stamp of approval,” he says. “They had no authority to keep others out. And I’m sure that it would have been difficult if people had actually come in with IRB-approved research projects from (elsewhere). But the governor of Oklahoma was quite clear about that and, in fact, they did coordinate all the studies.”

Fleischman says this step helped avoid survivors and their families being overburdened by repetitive attempts to recruit them for studies. He found this idea so compelling that he himself proposed a similar idea to New York City Mayor Rudolph Giuliani and the city’s commissioner of health, but he says that proposal was never acted upon.

“I suggested to the mayor and the commissioner of health that we create a blue ribbon panel that would be a clearinghouse and would put a put a star of approval on those protocols they had reviewed in order to try to decrease burden and to bring together collaborative projects that might be doing the same kind of work.”

Fleischman’s vision was of a panel of past Nobel laureates from the city. The panel would not itself be an IRB, but would tell IRBs which protocols they should consider. He says he still thinks the idea has merit, and could be useful in a future emergency.

Meanwhile, his institution was rapidly developing a set of guidelines to use when the academy’s IRB reviewed the first research proposals it would see involving Sept. 11 survivors and others affected by the attacks.

“We developed these guidelines on Sept. 14, when our researchers came to us to say, ‘We want to do this work,’” Fleischman says. “And we said, ‘We want you to do the work, but we think we ought to worry about this a little bit.’ Because we could find no guidance.”

Fleischman says one important aspect of protecting participants was providing referrals for necessary mental health treatment for people psychologically affected by the attacks — whether they were survivors, relatives, or New York City residents who witnessed the events in person or on television. In most cases, these were people with pre-existing mental illness whose problems were exacerbated by the attacks.

To address this issue, Fleischman says his institution set up toll-free hotlines for people who needed help. Research assistants who conducted telephone surveys were specially trained to probe for mental illness, and refer the respondent to a hotline.

For severe cases, where it was believed that a respondent needed immediate mental health intervention, psychiatrists were on call.

“We could put them on hold and get a psychologist who was on beeper availability,” Fleischman says. “We did that twice in 4,000 interviews.”

Another concern was the large number of substance abusers in New York City who were suddenly cut off from their drug supply by the shutdown of traffic into the city.

“We were concerned that our drug-using population would have some unique kinds of problems,” he says. “So we, in fact, were prepared to refer people to immediate detoxification centers.”

**Data protection key**

At Mount Sinai Medical Center, research with Sept. 11 survivors and families raised different issues, most notably privacy and confidentiality of data.

It’s a problem that’s not unique to this research, and IRB Chair Jeffrey H. Silverstein, MD, says his organization already had been vigilant about privacy protections, partly in response to the requirements of the Health Insurance Portability and Accountability Act (HIPAA), which had been enacted earlier in 2001.

In addition, “One of our largest portfolios here is our psychiatry department, so the sensitivity of data is something that we as an institution had a tremendous sensitivity about,” he said.

With large-scale studies of survivors, including sensitive psychological data, beginning at the same time as the HIPAA protections and concerns about identity theft, Silverstein says Mount Sinai officials put a lot of effort into security issues.

“There are a lot of people who want access to these data sets,” he says. “So we spent a lot of time thinking about how you secure them, while giving your researchers access to stuff. You can’t have people walking around with identifiable data about tens of thousands of people.”

There also was the worry that data could be sub-
poenaed for use in litigation, but Silverstein says that so far, that has not been a problem.

“We’ve discussed the utility of (obtaining) certificates of confidentiality; however, this is not like a pure data set, it’s a clinical data set, so it’s probably not going to be protected by a certificate of confidentiality if someone starts trying to use it for litigation purposes.”

Silverstein says there has been one major security breach associated with Sept. 11 research at Mount Sinai. Last year, a subcontractor’s laptop was stolen containing personal medical information from city workers who were participating in the World Trade Center Medical Monitoring Program.

“We eventually got it back, but we had to write 10,000 letters to people saying we lost it and then we had to write 10,000 letters saying we got it back,” he says. “That misadventure has resulted in a tremendous tightening down of security regarding databases in general. It could have happened to any major data set, but it happened to be the World Trade Center data set.”

Silverstein says that an institution embarking on this type of huge collection of data needs to ensure it has the necessary infrastructure to store and protect it.

Other issues that Fleischman and Silverstein say that IRBs should consider in dealing with the aftermath of terrorist related disaster:

- Patriotism and duty in voluntary participation — Fleischman says there’s been some concern among ethicists about the possibility that people in the throes of a national disaster, especially a terrorist attack, will feel a greater-than-normal compulsion to volunteer for research, seeing it as a patriotic duty.

“I think it was not unusual (in the aftermath of Sept. 11) for Americans to feel they were willing to give of themselves, which is an interesting question in research — whether this becomes an additional concern,” he says. “I think it is only a concern in that we shouldn’t play on that in the consent process. We should make sure the consent doesn’t add this message that ‘Americans ought to do this for the sake of the future of America.’”

“I’m not overly worried about it. I think it’s just a matter of not selling too hard, which is one of the IRB’s jobs (to monitor) anyway.”

He says special care should be given to protecting firefighters and police officers, whose situations may make them more willing to volunteer for this type of research.

“You have to make sure they are able to give true voluntary refusal,” he says. “In that kind of a setting, a quasi-military setting, somebody may not be able to do what he wishes to do in the face of peer pressure.”

- Community concerns — IRBs have always been charged with taking local concerns into consideration when reviewing protocols. This becomes doubly important when outside researchers are entering a community on a large scale.

Silverstein says one researcher approached his IRB with a proposal to monitor the population who lived close to the World Trade Center in lower Manhattan.

“He had a set of surveys that were relatively mild, but he wanted to do it only in English,” he says.

“The IRB pointed out that everybody who lives there lives in Chinatown — they all speak Mandarin.”

“Basically, they convinced the investigator that if he really wanted to know what happened to the people who lived under the Trade Center, he’d have to come up with a way of dealing with people in Mandarin.”

Fleischman says researchers also needed to work with a distinct community of survivors and their families, bound not by geography or language but by their shared experience.

“In much of the work in New York, we’ve involved the families of 9/11 victims,” he says. “They’ve been a very vocal group, but they’ve also been very powerful in helping research. Because they’ve seen the importance of doing research on how to build safer buildings, how to develop better plans for evacuation, how to educate people about these risks, how to develop community strategies in bioterrorism.

“They’re very much in favor of research, but they want it to be effective and useful. They don’t want any trivial self-serving research; they want work that’s really going to have an impact.”

Use these guidelines in disaster research

Those affected are not necessarily vulnerable, but be watchful for potential problems

A group of mental health professionals, trauma researchers, ethicists and IRB representatives have published a set of ethical guidelines for research with victims of disasters. They include:

- Assuming that those affected by disaster have the capacity to provide true informed consent to research. Questions about individual participants’ ability to give consent should be determined on a case-by-case basis, using assessment tools such as the MacArthur Competence Assessment Tool for Clinical Research (MCCAT-CR).

- Not making blanket assumptions that disaster-
affected populations are “vulnerable” per se for regulatory purposes. But research proposals should consider the psychological state of individuals and have plans in place to refer them for mental health help, if necessary.

- Reviewing proposals based on the level of risk, the nature of the research and the uncertainty of risk vs. benefit. This may require imposing additional safeguards for participants;
- Recognizing the critical need for more research on the risks and benefits of participation in disaster-related research;
- Wherever possible, including representatives of the community where the research is being conducted in planning and implementation of studies.
- Being extremely clear to participants about whether a proposed study has any therapeutic benefit. IRBs should take care to ensure that informed consent procedures reduce the possibility of therapeutic misconception.
- Conducting research in a safe, controlled environment.
- Making explicit provisions for confidentiality and protection of data.
- Making results of the research available to participants.
- Coordinating among researchers and IRBs to help minimize repetitive studies and participant burden.

Reference

**Specialized IRB could help community-based studies**

**Different membership, ethical principles required, argues researcher**

Community-based research requires a special type of review, and so should have its own type of review board, one that balances the responsibilities that IRBs have to individuals with an appreciation for the needs of the community in which research is conducted.

That’s the proposal of a toxicologist who has conducted environmental community research. **Stephen G. Gilbert, PhD, DABT, is director and founder of the Institute of Neurotoxicology and Neurological Disorders, Seattle WA.**

Gilbert says his new approach to community-based research in part was prompted by studies he conducted of environmental toxins such as lead and mercury and their role in child development.

He published his proposed community-based research review model in the October issue of the journal *Environmental Health Perspectives*.

Community-based participatory research, which involves community members in various phases of the planning and execution of studies, brings special challenges for both researchers and those reviewing the proposed research.

It can be difficult to determine who within a community should be included in a project, and how their ideas and concerns should be addressed.

“Looking at community-based research is a really different approach than what traditional IRBs are usually focused on,” Gilbert says. “You’re trying to figure out nuances, bringing the business community in there, other community members.”

IRBs are required to have a diverse membership, including non-scientific and non-affiliated members. But Gilbert says fulfilling that requirement alone doesn’t help an IRB prepare to deal with community-based research — in part because many of those “lay members” aren’t really from the communities being studied.

“They’re usually chosen from members of the clergy or somebody from an academic background, somebody highly educated who’s really not a community member in that sense,” he says.

He proposes an entirely different board — an environmental health and community review board (EHRB), with a different type of membership and even different standards for reviewing research proposals.

While his chief interest is in environmental work, Gilbert says he could see this type of board in other areas of community-based research as well.

“You take work on asthma, for example,” he says. “For a drug trial on asthma, if a certain community has high rates of asthma, it might have implications for a community like that, too.”

**Who is affected?**

Gilbert uses a study of blood lead levels in children as an example of how community-based research has special needs that might be better addressed by an EHRB.

“You want to go in there and sample children,” he says. “That’s got enormous implications for the community. Let’s say you’ve got an apartment building with seven or eight units and a couple of kids in
those units are showing up with lead exposure.

“What are the implications for the other renters of those apartments, what are the implications for the apartment owner? And the whole area could be re-lined (discriminated against for home loans or insurance). There are implications for the school system.”

There are privacy issues involving how much families need to know about other families’ results.

Gilbert says all of these questions bring different constituencies to a discussion of a study, and should be considered by the board.

An EHRB that might handle such issues ideally would be based in the community, rather than at a large academic medical center or university, Gilbert says. It could be sponsored by a non-governmental organization or associated with a local medical clinic.

He says it’s important that it meet in the community, so that residents and other interested people don’t have to travel outside their community and navigate a complicated bureaucracy to be heard.

“If an institution has six or seven different IRBs, it doesn’t build capacity within a community to understand these issues or figure out how to work with the IRBs,” he says.

Since the board would function in place of an IRB, it would need the same sort of human subjects protection expertise, and would need members who understand how research is conducted, Gilbert says.

“(Community members) don’t even need to be the dominant members, but I think you need to have more than just one,” he says. “You need at least two or three, so you’ve got a group there that can lend support to each other and ask the questions.”

“Things move very quickly, there’s a lot of specialized language that gets used,” he says. “And one individual, unless they’re extremely strong-willed, has a very hard time slowing them down and asking them questions.”

Gilbert says he would like to adapt even the ethical principles established in the Belmont Report to deal with the special concerns of community-based research. Gilbert sees this not as a replacement for Belmont’s principles, but as an expansion of them. His list of principles includes:

• Dignity, which Gilbert defines as not only respect for individual autonomy, but the recognition of the worth of an individual within the community.

“This acknowledges that people, especially children, have a right to develop in an environment in which they can reach and maintain their full potential,” Gilbert writes.

• Veracity, or a requirement to present all the relevant facts. “At all times, there must be a commitment to a right to know and a right to understand.”

Gilbert sees the community using this approach to use the facts to determine beneficence in research. It requires that communities learn all the necessary facts, even those that individuals or businesses might not wish to share.

• Justice, which Gilbert says needs to be expanded beyond the individual to ensure justice for the community in which research is conducted.

• Sustainability, a new concern that an EHRB would bring to its decision-making. Gilbert says a board would have to determine whether actions being contemplated would help sustain the community in the long term.

“You don’t just have somebody plop in there, do a study and then bail out of the community,” he says. “They need to be looking toward what they’re doing to help and sustain the worth of that community, improve the capacity of that community. And to sustain the research, too. Can you really work with the community so you can go back and they respect what you’re trying to do?”

**IRBs can adopt idea**

While the establishment of a new type of review board would require regulatory intervention, Gilbert says there are elements of his approach that could be instituted at a local level by individual IRBs.

At a minimum, he says, research institutions could create their own separate community-based research IRBs, to handle these types of studies.

“It would be helpful to have a long-term commitment to do that, bringing in more community members and trying to go to the community for your meetings, instead of putting them downtown where it’s a little more difficult for community members to get there,” Gilbert says. “I want to shift the burden of responsibility to the IRBs in a sense to reach out to the community, to include them, not just as a token effort.”

---

**COMING IN FUTURE MONTHS**

- Create a binder with IRB office instructions
- What’s best review strategy for research involving existing data?
- Here’s how to assess emergency exception to informed consent
- Protecting participants in epidemiological research
- Improvements in coping with HIPAA
“We need to consider the overall worth of the community and individuals, not just respect for the decision-making,” he says. “How we support and grow our communities, respect the community and the culture in which people live.”

Reference
Gilbert SG. Supplementing the Traditional Institutional Review Board with an Environmental Health and community Review Board. Environmental Health Perspectives 2006 Oct;114(10):1626-9. An online version of the article is available at no charge at www.ohponline.org

CE/CME questions

21. In 2005, how did the IRB review and approval process rank among the most commonly listed causes of trial delays?
   A. First
   B. Second
   C. Third
   D. Fourth

22. IRBs that work to develop evidence-based IRB practice might ask critical questions and gather data to find answers that support their IRB practices. Which of the following would not be an important question to ask?
   A. Is the IRB meeting too often or too infrequently?
   B. Do the meetings run too long?
   C. How much staff are needed to properly handle the workload?
   D. All of the above are important questions to ask.

23. Research conducted in the wake of the Sept. 11 attacks showed:
   A. That trauma research conducted with survivors of disasters did not cause the degree of emotional distress that had been previously believed
   B. That being asked about a disaster “traumatized” survivors, causing great emotional distress.
   C. That people who have been affected by a disaster cannot give true informed consent.
   D. None of the above

24. An environmental health and community review board (EHCRB) would take what research principles into account when considering community-based environmental research?
   A. Truth, justice and scientific rigor
   B. Risk vs. benefit, vulnerability, community values and dignity
   C. Dignity, veracity, justice and sustainability
   D. Respect for persons, beneficence and justice

2006 Index

When looking for information on a specific topic, back issues of IRB Advisor newsletter, published by Thomson American Health Consultants, may be useful. To obtain back issues, contact our customer service department at P.O. Box 740060, Atlanta, GA 30374. Telephone: (800) 688-2421 or (404) 262-7436. Fax: (800) 284-3291 or (404) 262-7837. E-mail: ahc.customerservice@thomson.com. Managing Editor: Leslie Hamlin.

Accreditation
JCAHO, NCQA dissolve accrediting body. OCT:115

Accreditation
AAHRPP accredits its first international site AUG:95

Adverse event reporting
Improve SAE reporting with electronic submission JAN:07

Community-based research
Family medicine group suggests guidelines JAN:05
Specialized IRB could help facilitate community-based studies DEC:142

Disaster planning
Lessons from 9/11: Protecting subjects in disaster research DEC:139
Use these guidelines in disaster research DEC:141

Education
Flexible continuing ed meets varied needs JAN:03
CIP certification is taking off among IRB staff JUL:82

Ethics
Family medicine group suggests guidelines JAN:05
South Korean research controversy raises questions about oversight FEB:13

Tips for IRBs overseeing international research FEB:15
Community ethics training program wins award FEB:22
AMA unveils health care ethics toolkit FEB:23
NIH's ethical framework wins award for excellence MAR:30
NIH's 7 principles relating to clinical research ethics MAR:32
Think far beyond ethical requirements set in regs MAR:34
How much oversight for QI activities? APR:43
Clinical trial problems in England raise ethical questions in US MAY:49
New journal focuses on research ethics JUN:69
Scientists say rules and pressure to produce lead to everyday misbehaviors JUL:73
Over regulating can put subjects at risk JUL:75
Fairness and common sense can ease tensions AUG:89

FDA
The FDA launches guidance initiative MAY:55
GAO: Improve post-approval drug oversight JUN:71
SACHRP chair updates IRB Advisor on IRB regulations SEP:100

HIPAA (Privacy Rule)
De-identification software for researchers and IRBs MAR:28
HIPAA regs require firm policies, documentation JUL:81

IRB issues
IRB streamlines process to improve response time JAN:09
Optimization committee helps with consistency FEB:17
Regional consortium gives IRBs venue for information APR:46
Liaison efforts can improve compliance MAY:56
CIP certification is taking off among IRB staff JUL:82
How IRBs can improve investigators' opinion AUG:91
IRB assessment tool AUG:92
IRB director offers guidelines for running a more efficient office SEP:97
Sharing of IRB approvals raises questions, concerns SEP:99
Be creative in seeking out unaffiliated members SEP:106
Research tries to get a handle on IRB costs and variability NOV:121
IRB delays help slow drug pipeline: Here's what you can do about it DEC:133
Letter to editor: Streamlining reviews might send wrong message DEC:135
Build proven efficiencies into IRB process DEC: 136
Informed consent
Consent, confidentiality key in PTSD research MAY:54
Creative suggestions for getting consent from decisionally impaired JUN:61
Excerpt from reporter's consent form AUG:88
Listening, interactive media transform informed consent AUG:93
New approach surveys subjects to measure informed consent OCT:114
IRBs sometimes go overboard in requiring risk details in consent OCT:116
Do research subjects retain informed consent details? NOV:123
Some studies are right for short form, with precautions NOV:125

International research
South Korean research controversy raises questions about oversight FEB:13
Tips for IRBs overseeing international research FEB:15
Clinical trial problems in England raise ethical questions in US MAY:49
UK clinical trial disaster: Five subjects sent home JUN:70
PRIM&R takes IRB training to international sites NOV:126

Multi-site review
Sharing of IRB approvals raises questions, concerns SEP:99

OHRP
Historians, OHRP and IRBs looking for common ground on oral history projects MAR:25
Register now for Duke OHRP conference AUG:95
SACHRP chair updates IRB Advisor on IRB regulations SEP:100

Quality improvement
Family medicine group suggests guidelines JAN:95
IRB streamlines process to improve response time JAN:99
How much oversight for QI activities? APR:43

QI program identifies deficiencies, educates JUN:64
Small IRB develops, finds ideal solutions to problems NOV:128
Build proven efficiencies into IRB process DEC: 136

Regulatory issues
Are you up on your state's research requirements? JUL:77
Resources to find state laws affecting IRBs JUL:79
SACHRP chair updates IRB Advisor on IRB regulations SEP:100

Research subjects
IRB puts its imprint on recruitment registry JUN:63
More older women avoid research participation JUL:79

Social-behavioral research
Do you have measures in place to protect student participants? JAN:01
Family medicine group suggests guidelines JAN:05
Are third parties due protection? FEB:18
Historians, OHRP and IRBs looking for common ground on oral history projects MAR:25
Mission creep: White paper makes case that IRBs have gone too far at field APR:37
USC booklet provides answers about human subjects research APR:40
Are marginal research activities clogging IRBs? APR:41
Research is changing IRB views about PTSD studies MAY:51
Consent, confidentiality key in PTSD research MAY:54
Liaison efforts can improve compliance MAY:56
Different disciplines, similar challenges MAY:58
New journal focuses on research ethics JUN:69
The reporter and the IRB: Should IRBs get involved in investigative journalism? AUG:85
Excerpt from reporter's consent form AUG:88

Ethnography proposals pose problems for IRBs SEP:102
Dealing with ethnographic issues SEP:104
IRBs sometimes go overboard in requiring risk details in consent OCT:116
Lessons from 9/11: Protecting subjects in disaster research DEC:139
Use these guidelines in disaster research DEC:141

Stemcell/Genetic research
South Korean research controversy raises questions about oversight FEB:13

Technology
Improve SAE reporting with electronic submission JAN:07/Data customization possible with IRBANA FEB:21
De-identification software for researchers and IRBs MAR:28
Tailoring IRB software to different sized institutions APR:44
IRB puts its imprint on recruitment registry JUN:63
Electronic system improves IRB record management JUN:66
IRB can now move huge data files with technology JUN:67
IRB director offers guidelines for running a more efficient office SEP:97

Vulnerable populations
Creative suggestions for getting consent from decisionally impaired JUN:61
SACHRP chair updates IRB Advisor on IRB regulations SEP:100
IOM panel recommends changes to review of prisoner research OCT:109
Improving prisoner research now: What can IRBs do? OCT:112
Examples show how IOM recommendations on prisoner research would work OCT:113
Why isn't there more research into improving pregnancy conditions? OCT:117

December 2006 / Supplement to IRB ADVISOR