IRB ADVISOR

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The ethics police? New book issues challenge for change

Calls for IRB training, standardization, appeals system

By Gary Evans, Senior Staff Writer

In a controversial book that both damns and praises the so-called "ethics police," we are ultimately left to ponder a paraphrase of the classic Churchill quote on democracy: IRBs are "the worst system — except for all the others."

Meet **Robert L. Klitzman**, MD, director of the Masters of Bioethics Program at Columbia University in New York City, and the author of *The Ethics Police? The Struggle to Make Human Research Safe*.[1]

Conducting some 45 interviews with IRB members, he chronicles everything from the completely arbitrary nature of some of their appointments to their petty concerns and heroic struggles in the ethical minefield of human research. *(See related story, page 17.)* We enter this wide-ranging discussion of risks and benefits, consent and betrayal — all on the frontier of an explosion in genetic research that could magnify every facet of the enterprise — in part because Klitzman was once a young doctor with a father dying of leukemia.

HE CHRONICLES EVERYTHING FROM THE COMPLETELY ARBITRARY NATURE OF SOME OF THEIR APPOINTMENTS TO THEIR PETTY CONCERNS AND HEROIC STRUGGLES IN THE ETHICAL MINEFIELD OF HUMAN RESEARCH.

Given three months to live, his father was offered the option to try an experimental chemotherapy treatment and possibly extend life by as much as 18 months, says Klitzman, a clinical professor of psychiatry at Columbia. Noting that his mother thought it was too risky, Klitzman urged his father to pursue the experimental treatment. Hopes were

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dashed. His father's white blood cell count improved but the side effects of the treatment killed him three months later — meaning the treatment failed to extend life beyond the original prognosis. This "haunting" event is our starting point for a compelling conversation with the author of *The Ethics Police? (The interview has been edited for length and clarity.)*

IRB Advisor: Given this powerful personal narrative — and some of your admitted bad experiences with research delays caused by IRBs — did you question whether you could look at the issues objectively in your book?

Klitzman: IRBs have been controversial and I think it's important to look at any controversy from as many angles as possible. I argue that I bring different perspectives to it. On the one hand, I have been a researcher and have had to deal with IRBs and at times, frankly, that was frustrating. I have also been a family member who has seen how hard it is for families of patients to decide about research and experiments of some kind. But I also run a bioethics program and I'm very concerned about bioethics. I'm Jewish and I have read about the Nazis' experiments on Jews in concentration camps. It's horrific, and I'm glad that IRBs and ethical review have been established. I bring several different perspectives to try and understand IRBs.

In the book, I try to have IRB members speak for themselves. I worked with a great anthropologist for a number of years, so in trying to understand a social situation as a social scientist it's important to understand the perspective of the people in the situation. Rather than just impose our views from the outside, it's important to hear what people in the situation are saying. In the book, IRB members speak for themselves about the issues they see and face and how they deal with them.

I don't think I went into this too biased against IRBs or for IRBs in a way that influenced what IRB members told me and how I presented that. These are complex issues that need to be seen from multiple sides. I think my father's death led me to think about these issues and realize this is worth spending time on and understanding. And I have devoted several years of my life to studying IRBs and writing this book because I realized how hard it was to understand these issues — partly from having that experience. So I would argue that my personal experience led me to want to understand IRBs, but did not lead me to have a bias one way or the other.

IRB Advisor: Should there be more of an effort to inform people and patients in general about IRBs and human research, not just when they are asked to be research subjects?

Klitzman: Yes, absolutely. I have found that research subjects and the public at large know nothing about IRBs. Not only do they operate behind closed doors — that's a major problem, but they often, as I talk about in the book, don't want to be studied. We only hear about them when there is a scandal — when someone dies from an experiment, these issues come up. But I would argue that these are important issues and are ultimately about who we want to have data about us. There is 'Big Data' out there in the world, whether it is biobanks that hospitals have of hundreds of thousands of individuals, or it is a national security agency trying to get data on people based on doing experiments on us.

There is a tension between the fact that we want to advance science — science has brought us many wonderful things in our lives; I take cholesterol medication and

I'm grateful to the science that led to the development of that — but at the same time we need to protect the rights of people. We have seen what's it like to be railroaded into experiments or [as subjects and families] not to understand experiments. We know what happened with Tuskegee and we need to be sensitive to these issues. There needs to be more public understanding of these issues because they affect all of us.

IRB Advisor: You observe in the book that "given the importance of the work they do, and the potentially grave consequences of IRB lapses and oversights, the lack of preparedness for the work is especially striking. Both general members and chairs have been found to have little if any formal training in ethics." This impedes research, you argue, but isn't it also of some benefit to slow down research and carefully examine potential consequences?

Klitzman: IRBs do not need to slow things down. It's not a matter of time. If anything, having people that are better trained might speed things up and result in reviews that are both of higher quality and more rapid. Sometimes IRBs get hung up because people need to take on the ethical issues. The process could go more smoothly and I think in many instances could yield better results [with more training]. Right now there is no federally required training of IRB members. In some institutions it is required. Some members want to get it but is not [widely] required. You could be the chair of an IRB and have no training in ethics whatsoever.

IRB Advisor: You note some investigators criticize IRBs as "the ethics police" and complain that the boards unnecessarily block or delay studies. But as you point out, they were created as a firewall against unethical, if not criminal, research like denying available treatment with penicillin in the Tuskegee syphilis study. Are you concerned that similar, highly unethical research is still being conducted somewhere under the radar or have IRBs been an effective deterrent?

Klitzman: This is an important question and I would argue we really don't have complete data on this. My own sense is that the IRB system has had problems. One major set of problems is not about the research being unethical, but rather that the review process has gotten in the way of science without providing any more protection for people. The problem is that when the [Common Rule] regulations were issued in 1974, science was very different. Most research was by doctors in their clinics of maybe 100 patients. Now, to show that a new drug is significantly better than other drugs, I need 2,000 patients and I need to go to dozens of institutions, and so multisite research has become more common. As a result, 20 to 30 IRBs are reviewing the protocol and those IRBs often disagree. Some say this research is great, some say "change this," some say "change that." It gets much harder to pool the data from different sites. That gets in the way of research. The problem again is not that the research is unethical, but that the IRBs have impeded the science in ways that are not necessary.

> "THERE IS A TENSION BETWEEN THE FACT THAT WE WANT TO ADVANCE SCIENCE ... BUT AT THE SAME TIME WE NEED TO PROTECT THE RIGHTS OF PEOPLE."

I will also say, though, that there are two other problems. One is that there are still studies researchers do thinking they don't need IRB approval. Another problem is that sometimes IRBs — because they need more education to help them understand [research and ethical] issues — approve studies that end up being problematic.

For example, there is the case of the Havasupai Native American tribe that lives at the bottom of the Grand Canyon. They believe that they originated there and they have told [this origin story as part of their culture]. Land was taken away from them by white settlers over the years and they have high rates of schizophrenia, diabetes, and alcoholism. Researchers wanted to study that but were afraid if they told the tribe, "We are interested in your high rates of schizophrenia and alcoholism," the tribe would say no. So the researchers said, "We are interested in studying diabetes and other health problems." The IRB went along with that [protocol, which included taking blood samples for DNA research], but later the tribe found out that papers were being published about their high rates of schizophrenia and alcoholism and the fact that they came from Siberia, not the Grand Canyon. So there were lawsuits. That is a case where I would argue that the IRB could have — and I personally think perhaps should have — done a better job. So there are cases sometimes where IRBs approve research that leads to unethical [consequences]. Again, I think the problem is that IRB review needs to be much more rigorous, there needs to be better training,

etc. I would be surprised if there was another Tuskegee going on, but there are still unethical things that happen with IRB review or without IRB review. There are other examples where IRBs have approved research that has been problematic.

IRB Advisor: You call for clarity and standardization to address IRB problems and more transparency in interpretations and applications of principles in specific cases.

Klitzman: We need to be open to being studied. For example, a website where you say, "I think this is what we should do with this study — does anyone disagree?" Or, "Here is a controversial study — what do you think?" so more people can address the content. There have been studies published, for instance, that show that IRB chairs disagree whether an allergy skin test is minimal risk or not. There should not be disagreement on stuff like that. It is minimal risk or it is not — there is no reason for disagreement, so I think we need much more standardization. Then we need more training on [the consensus standards].

My background is in psychiatry and for many years one of the problems of research [was that psychiatrists disagreed about patient assessments]. There was disagreement about anxiety and depression, and ratings scales were developed over several years so we could all agree that this patient meets these criteria and is depressed or is not depressed. This has become the so-called DSM V diagnostic manual in psychiatry, which is controversial, too, but at least there have been efforts to all get on the same page in terms of making the same diagnosis. I think there needs to be similar work with IRBs to determine that they agree on certain standardized things that they have consensus on — things they now disagree on quite a bit.

IRB Advisor: You also make a kind of legal argument that "a body of case law" should be built based on documented precedents and complete with an appeals system.

Klitzman: I think there should be external appeals. For example, right now if a researcher disagrees with an IRB, he or she goes back to that IRB and they say, "No, we have made up our mind" — the researcher is stuck. There should be an external appeals process [like the] court system where you can appeal all the way up to the Supreme Court. Many of us may disagree with Supreme Court decisions, but the buck stops there and there is consensus.

IRB Advisor: You cite a need for "a change in attitudes" by all parties, getting away from the adversarial nature of IRBs and researchers. Can you give some examples of this?

Klitzman: Right now a lot of IRBs say, "Researchers cannot challenge us because we represent our local community values." But what I have found is that there may be five IRBs at one institution and they sometimes review the same studies because there are different researchers involved. The IRBs in the same institution and the same community disagree. They are not disagreeing because of community values. They are disagreeing because of [issues with] a researcher, or the institution has been sued — sometimes it is just the personalities of people in the room. There are all kinds of institutional and psychological factors. IRBs need to realize the ways in which they disagree about issues and that there may be more than one acceptable decision about a study.

Some researchers need to change their attitudes. A lot of researchers don't like IRBs — they call them the ethics police. What they really don't like are all the regulations, but the IRB is the "face" of the regulations. So when researchers say, "I hate the IRB," what they really mean is, "I hate having to follow regulations." They blame the messenger.

Another issue is that right now, according to the regulations, there should be one non-scientific member and one unaffiliated member. IRBs often say, "We have one person combining these roles, a community member." But, in fact, they are very different roles. [This person may be] a woman of color in a room full of white folks — mostly men. The community member feels intimidated or not empowered. There should be two different people in two different roles. And why not have three non-scientific members instead of just one?

Also, IRBs should have more support. Some institutions underfund IRBs. They are strapped and they can't do as good a job as they want. There need to be changes at the federal level, the institution level, the IRB level, and the researcher level.

IRB Advisor: Are any of the major problems with IRBs you identify in your book addressed in the recently issued Common Rule Notice of Proposed Rulemaking (NPRM)?

Klitzman: Not really. The NPRM says we should have central IRBs for multisite researchers. There are a lot of details that need to be worked out, but there are some advantages to that. But it doesn't talk about getting consensus, having more resources, being more open to research, having better training or any training required of IRB members. External appeals is not addressed, changing attitudes is not addressed. The Notice of Proposed Rulemaking does not address [these issues]. I think it could and it should, but some of this does not require changes in federal law or regulations. I think if the Office of Human Research Protections said these are important things, that would do a lot. They could say, "we 'strongly recommend' that there be training of a certain kind and standards based on

consensus." Something could be done at the federal level that does not involve regulations per se.

IRB Advisor: You found that IRBs "wrestle with genuine dilemmas and are constantly trying to weigh possible future risks and potential benefits of studies that have not yet been conducted." It seems the problems you describe are only going to be aggravated by the explosion of genetic research underway and expanding.

Klitzman: Absolutely, IRBs don't know what to do in the area of genetics. This is one of the areas the NPRM guidelines are asking what should we do with biospecimens and genetic samples? Nobody knows, so in the proposed rulemaking as I understand it says you need consent if you are going to have the specimens — even if they are de-identified. But if I have the data, I don't need separate consent. The problem is — say I get your blood sample and work up your whole genome sequence. I can throw away the sample — I have the DNA. The proposed rule says researchers can study whatever they want on the data; they just can't use the actual specimen. Some people may not want to be part of a research study and I can't use the actual specimen, but if someone sequences a specimen and gives me a computer printout of the data, I can go ahead with the study. That is not exactly logical. Another area that is proposed for change is that consent forms should be posted online, which I think is good. But the [rule] says it would be done after the study is done. I think it should be posted beforehand so there can be more transparency.

REFERENCE

1. Klitzman, RL. (2015) The Ethics Police? The Struggle to Make Human Research Safe. New York: Oxford University Press. ■

IRB members in their own words

'I worry — is the study truly safe?'

Author Robert L. Klitzman, MD, interviewed some 45 IRB members for his new book, *The Ethics Police?*[1] The following are some of the published comments by both IRB chairs and members on how they came to be on an IRB and their challenges in weighing the risks and benefits of human research.

• "I was volunteered. My chairman said that the department needed to appoint someone to the IRB. I was now 'it.' But I was surprised — I had no training in ethics."

• "I was a statistician and started on the IRB because my interest was research. I saw this as a way to familiarize myself with a hospital on a research level."

• "We think it's pretty important that the IRB chair be a practicing researcher, and we want lots of researchers on the IRB who have the respect of their colleagues and are pretty distinguished so that they can't be intimidated by any department heads or vice presidents."

• "It's very hard to weigh risks and benefits. Everybody has to make calculations on their own. We thought a drug might help a sick man, but a side effect was stroke. The likelihood was extremely small; but one patient turned it down because his mother had had a terrible stroke. He was a sick man, why would he turn down the possibility that this could help him for a 2% chance of stroke? He couldn't take that risk. All the IRB can do is try to make things as clear as we can. We have 'likely,' 'less likely' and 'rare but serious' [risk categories]. I think likely is 20%, which in my mind is not likely. I would say likely is 50% to 60% — better than an even chance."

• "Some people just like to argue, nitpick, and be critical. You can't have people like that. But you don't want people who are just going to put in their time and leave and not read protocols carefully!"

• "I worry — is the study truly safe? We do a lot of studies that are potentially high risk. We worry but have to trust the investigator. That's why we look so carefully at the progress reports."

• "Being cautious is the IRB's job, but they may be overly cautious. For most IRBs, nothing good can come from approving a protocol. Every time you approve a protocol, there is a risk for bad things happening — including bad press."

• "Members are so committed and hold themselves to standards in terms of doing the right thing, carefully reading and analyzing — taking it all seriously trying to protect subjects. It's very inspiring and it makes me want to do a better job."

• "One of the challenging things about being a leader is mediating differences in opinion. Usually we come to a pretty easy consensus. But some cases elicit strong opinions on either side: not approving, or requiring something. That is always challenging — having the skill to further explore members' thinking and reasoning."

REFERENCE

1. Klitzman, RL. (2015) The Ethics Police? The Struggle to Make Human Research Safe. New York: Oxford University Press. ■

IRB and IT collaboration can reap HRPP rewards

Improved data security is chief goal

IRBs and researchers likely underestimate their vulnerability to data security breaches, which are a growing problem across the healthcare industry. Data breaches and security issues, including criminal attacks, have grown to become an enormous problem in healthcare, according to a 2015 study by the Ponemon Institute (www.ponemon.org).

The study points to a five-year trend of increased criminal attacks. Previously, employee negligence and lost or stolen devices were the primary causes of data breaches; now, it's criminal attacks, and no institution — no matter its size — is immune.

One strategy for protecting research data and human research protection programs from cyberattacks is to form a collaboration between an institution's information technology (IT) department and the IRB.[1]

When they work together, the result is improved data security, says **Susie Hoffman**, RN, BSN, CIP, director of the University of Virginia IRB-HSR (Health Sciences Research) in Charlottesville.

"Working with personnel from our IT department has been a learning process," Hoffman notes. "We come from different cultures with different goals, different objectives, different language, so it's really an evolution of trying to make a process that works for both offices."

The University of Virginia Information Security, Policy, and Records Office (ISPRO) reached out to the IRB about collaboration because the IRB was a gateway to researchers who needed information about better data security, says **Tim F. J. Tolson**, PhD, information security and policy analyst at the ISPRO.

"We saw this as a way to leverage what the researcher already had to do for the IRB," Tolson explains. "We always have encouraged people to contact us, but we don't have the leverage to make people contact us."

Initially, the IRB and ISPRO shared policy guidelines and definitions to provide researchers about data security. This eventually grew into a formal process in which ISPRO reviews certain research studies, assessing their data security.

"When we had a new protocol come through that wanted to collect highly sensitive data on a smartphone app, we realized we were in over our heads and didn't have the technical expertise to review the protocol," Hoffman says. "So we turned to our colleagues in our ISPRO office. They quickly determined that the security measures the researchers had established were inadequate and would need to be replaced."

This led both the IRB and ISPRO personnel to the conclusion that it would be far more efficient and better for investigators if data security experts could review and guide data security plans preemptively.

"Researchers want to do the right thing, but they're not sure what that right thing is," Tolson says. "We understand the primacy of their needing to get the research done, but what we're going to do is find the most secure way to accomplish what they need to get done."

The solution was for ISPRO to add IRB protocol reviews to the existing duties of one staff member at first, and as work grew, add responsibility for reviews to a second staffer.

Tolson and Hoffman describe how the collaboration was established and works in the following ways:

• First, share and create policies. "The real first step was providing information about what the policies were," Tolson says.

Researchers increasingly were asking the IRB whether their data safety plans complied with policy, and — separately — neither the IRB nor ISPRO could fully answer that question, he explains.

"In the last five years, a lot of medical research has moved away from paper, and data collection is online in some format," Tolson says. "The IRB felt they didn't have the technical expertise to judge whether a data server was adequately protected or whether it was permissible to place data on a particular cloud service provider."

As IRB staff worked with ISPRO, they learned that researchers had been storing data in places that didn't meet the institution's security requirements, Hoffman notes.

"For example, researchers in one department had been storing all their data on a particular drive, and ISPRO staff discovered it wasn't behind the firewall," she says. "These kinds of issues arise because researchers are not IT experts."

So the IRB needed a process for identifying which protocols would need additional data security and technical assessment, Hoffman says.

"We wanted ISPRO staff to review the protocols, but they didn't have the personnel to review every single protocol that comes through our office," she explains. "So we wanted to take advantage of their expertise when it was most needed."

The solution was to screen protocols with an additional question about

data security. The IRB and ISPRO staff worked together to develop the question.

Researchers are asked the following:

Will you do any of the following in this study?[1]

- Collect or store identifiable data onto an individual use device?

- Collect or store identifiable data via Web-based format via a non-UVA server?

- Collect or store identifiable data on the cloud?

- Collect or store to a server not included in the list of HIPAA-compliant servers?[1]

• Develop a data security plan. All researchers are required to complete a data security plan which asks for security details and documents the researchers' plans for collecting, transferring, and storing research data. Review by the data security experts is only required if researchers answer "Yes" to the question. The IRB will not approve the protocol until an ISPRO approval is received.[1]

"Basically, the plan asks, 'How are you going to collect the information — on a tablet, smartphone app, on a piece of paper? — and what identifiers are going to be with that information?'" Hoffman says. "We had to break down the process into three steps: How are you going to collect the data? If you are transporting the data anywhere, how are you doing it: email, mail, faxing? Where are you storing the data?"

The ISPRO review evolved as part of the collaboration, Tolson says.

The IRB and ISPRO had different priorities when it came to assessing data security in research protocols. From the IRB's perspective, these assessments were time-sensitive. From the ISPRO perspective, these assessments were important, but could be held if an immediate institutional data security issue arose, Tolson and Hoffman say.

"We were not used to working on those timelines, so we had to develop a process where data security review happened before the researcher submitted a formal protocol to the IRB," Tolson says. "That's been the heart of collaboration between our two groups: working to get the review done in a way that meets IRB timelines."

• Determine way to rate security risks. "Questions in the data security plan help the study team determine whether a study's data is highly sensitive or moderately sensitive," Hoffman says. "Then the privacy plan in the protocol provides concrete, specific examples of what researchers are allowed to do with data that meets either of these criteria and how to abide by institutional policies."

"For instance, if you have highly sensitive data, such as identifiable health information, it has to be double-secured — either locked in a file cabinet and locked room or in an office that is locked in a building that is locked down," Hoffman explains. "If data is electronic, then it has to be stored on one of the HIPAA-compliant servers. The information may not be placed on a flash drive or laptop; it may only be accessed via a VPN."

For moderately sensitive data, which might be data that meets the criteria of a limited data set, only one level of protection is required, such as a locked file cabinet. The electronic data could be stored on a flash drive or laptop, she adds.

The only data that would be deemed not sensitive would be information that could be posted on a company website, Hoffman says.

• Obtain buy-in. ISPRO and IRB employees have adapted well to the collaboration, Tolson and Hoffman say.

"I was pleased they were as interested as we were in how researchers store and handle data appropriately and securely," Tolson says.

Also, Tolson and Hoffman worked together to present information about research and data security to research coordinators and investigators.

"We tried to make it a very open process to researchers to let them know we value their input about what works and what doesn't," Tolson says. "We're not here to obstruct or prevent what they do; we're here to help them do it in a secure manner."

While some IRBs might handle data security and protocol issues by having an expert on the IRB panel, this was not the best solution for the University of Virginia IRB, Hoffman notes.

"We didn't want the IT security expert to have to sit through IRB meetings and listen to protocols that had no security risk. That's why we decided to handle this separately, outside of the full board, just like radiation safety or pharmacy approval," she explains.

The collaboration has resulted in open communications between researchers, IT security staff, and IRB staff, Tolson and Hoffman add.

"The collaboration has been wonderful because they have been very willing to hear what we have to say and make adjustments to their processes," Tolson says. "And on our side, we've been trying to adjust and accommodate the things that are important to them."

Hoffman agrees: "We're now on a first-name basis, and we can call each other whenever we have a question," she says. "Researchers know who the IT experts are and they know to go to them if their study involves a process that might increase the data security risk."

REFERENCE

1. Hoffman S, Davis B, Tolson T. Improved data security via collaboration between the information security office and the IRB. Presented at the 2015 PRIM&R AER Conference, held Nov. 12-15, 2015, in Boston. Poster 22. ■

IRB develops improved staff training for new hires

Training can reduce turnover

When an IRB office received feedback from new hires that its training and guidance for new IRB employees was lacking, something had to be done.

IRB leaders decided to address concerns through development of a standardized training program for all new staff members. The program involves having multiple people in the IRB office provide training, says **Scott S. Katz**, MS, CIP, research protocol analyst for the Emory University IRB in Atlanta.

"We decided on a written format," Katz says. "We wanted to reduce errors."

The changes led to a more effective training program, according to staff feedback and internal audit data.[1]

"The training fosters relationships and is about improved office relationships," Katz says. "Everyone is getting to know each other, and it re-educates staff members as they are teaching the new employees."

It has reduced the amount of errors new staff members make, and it has reduced overall errors as well, he adds. "We're finding that everyone is better trained, and they're more on the same page now; the office is a lot more efficient than it was before."

This is how the program works:

• **Advance preparation:** The first step is preparation for the new employee, Katz says.

"Our training process starts roughly one to two weeks before the new staff member joins our team," Katz says. "During this time, the staff training liaison makes sure that the desk is ready for the new member, checks to see that all materials and permissions are present, and sends out a sign-up list — a Google doc — for all of the current staff members to sign up for a specific day to conduct the training."

Once the training begins, the liaison will monitor the training and make sure that all of the staff who signed up know what and when they are signed up for, and covers for any days that were not selected, he adds.

"The liaison makes sure the go-to staff member is introduced to the new staff member," Katz says.

The new staff member is given access to a website that can only be accessed with a specific URL. The website has all of the information the new employee will need to know, he adds.

• **Go-to staff member:** Each day of training is organized around a specific type of training, and different staff members participate in training the new employee.

"The current member who is doing the training for that day is known as the go-to staff member," Katz says. "The go-to staff member will then meet with the new staff member for an hour or more to discuss the daily training, show the new member how to process studies using eIRB, and then quiz the new member on what they have learned."

For example, on the first day, the go-to staff member will meet with the new employee and discuss the IRB's background and why the IRB review process exists, Katz says.

• **Background reading:** "During the day, the new member is not only learning by instruction, but also reading over all of the relevant regulations, policies, and readings," Katz says.

For example, the new employee is expected to read through the standard operating procedures (SOPs) and then apply them in the next day's training, he explains.

• **Daily modules:** IRB new staff training includes the following modules:

- Historical and administrative: "We introduce them to SOPs and the Common Rule," Katz says.

- Expedited review: The go-to staff member walks the new employee through the expedited review process, using actual studies in the IRB office's inbox, Katz says.

- Non-human subjects research determinations.

- Informed consent and HIPAA — a deeper look: Training about informed consent includes reviewing multiple informed consent documents, he says.

- Exempt review: "We go over all of the regulations, policies, and procedures involved with exempt studies and making those determinations," Katz says.

- Laying foundation for a full board review.

- Full-board study review: "Sometime during the two weeks, we want the new employee to attend one of our full board meetings to get a feel for how it works and to see how the reviewers make these determinations," Katz explains.

- Amendments, continuing reviews, misc.

- Putting it into practice: minimal risk studies.

- Putting it into practice: more than minimal risk and adverse events.

- New staff training feedback and pod assignment: On the feedback day, the new staff member meets with the IRB director and discusses whether he or she feels comfortable moving forward. The new member also gives feedback on the training program, what worked, and whether any improvements could be made, Katz says.

During each day and module, the go-to staff member is there to provide guidance and to show the new employee where to access information.

• Feedback of training program: "At the end of each day and upon the completion of the course, both the new staff member and the go-to staff member are asked to provide anonymous feedback through a Google doc," Katz says. "This feedback is then used to enhance our training program for the next new employee."

New staff members can use an anonymous feedback form.

Feedback has been very positive, he notes. "People have praised the new training program and how well structured it is."

The feedback also has identified areas where additional information was needed, he adds.

The training program's greatest asset is its structure, Katz says.

"Everything is on a website the new member can access, so each day the person is not lost; they understand what needs to be accomplished during the day," he says. "Because it's online, they can go home at the end of the day and read up on regulations."

REFERENCE

1. Katz SS, Wack K, Arenson M, et al. Transcending turnover by standardizing staff training. Presented at the 2015 PRIM&R AER Conference, held Nov. 12-15, 2015, in Boston. Poster 3. ■

Improve evaluation of IRB's QI/QA processes

Track review times

IRB offices need a systematic approach to quality improvement (QI) processes. They also should have a way to evaluate performance, subjecting the office to internal scrutiny, an IRB expert says.

"There are simple ways to do this," says **Nichelle L. Cobb**, PhD, director of the health sciences IRB office at the School of Medicine and Public Health, University of Wisconsin-Madison.

"There are simple projects and ongoing projects that every IRB office should have in place," Cobb adds.

For instance, IRBs could track review times for IRB members who do expedited reviews, she says.

"You can see how long the reviews are for each type," she says.

Whatever the current review time is, a new QI goal could be to lower that time, Cobb adds.

Cobb offers the following additional tips on improving IRB processes:

• Review individual staff data. Review processes can vary according to which IRB professional is handling them, and data on individual performance can be useful, Cobb says.

"We have to address variability, how many studies each person has, and how [long it takes them] to get through them," she adds.

IRB directors can adjust workloads more efficiently once they have this information. Also, these data can be used to show leadership why the IRB needs additional staff, she says.

• Understand your processes for managing multisite studies. IRBs increasingly are being nudged into collaborative review models. When an IRB is the central IRB for a study or agreeing to accept another IRB's review, there need to be processes in place to manage these collaborations, Cobb says.

Process improvement might focus on communication between the IRB of record and study sites, as well as address differences in state laws and institutional requirements, she adds.

"Spend time getting to know your colleagues at other institutions," Cobb says.

When an IRB relies on another IRB for the protocol review, it should make sure its own institution's study teams are complying with the IRB of record's institutional policies. "They might have different policies and requirements for noncompliance reporting," Cobb adds.

• Select something to improve and follow through with it. "I recommend that IRB offices consider picking a topic and following through with that area for a spot check project," Cobb says.

For example, suppose an IRB is the IRB of record for another institution. Then the spot check project could be to make certain its policies and procedures, checklists, and consent documents comply with the revised policy handbook of the other institution, she explains.

The IRB could even assign a staff member to look at the other institution's consent document from 10 recent studies — that occurred after the handbook change — and make sure the changes were in it, Cobb says.

A short evaluation form might be used to assess whether the IRB had approved consent documents with all updated requirements. If missing items

are identified, the IRB can send an email to the study team, saying, "Hi, we did an internal audit and would you please change this," Cobb says.

• Audit the IRB, as well as study teams. "IRBs need to have systems where someone can check on the IRB's work," Cobb says.

"For example, a quality control measure we use is reviewing IRB minutes," she says. "Are we explaining our basis of determination in them so someone from the outside would know which regulation we're basing this determination on?"

The goal is to make sure the IRB's minutes are as consistent as possible with determinations and communication, she adds.

• Track IRB metrics and review weekly reports. Whether an IRB has an electronic system with easily generated reports or a paper system with manually pulled reports, metrics tracking and reporting is important. Someone on staff should be able to access and assess IRB metrics, including the time frame from protocol submission to IRB review and every step along the way, Cobb says.

The ideal person for this job is someone who understands metrics and their use in quality improvement. "We appointed someone who manages submissions and who became very good at metrics and quality improvement," Cobb says. "She developed a template and would write up what the project would be, how it was done, and what the results were in case we needed to recreate it."

It's important for IRBs to employ quality improvement methods because it shows the research community that the IRB cares about the process, too, Cobb says.

"Like everyone else, you're doing your best practices and making adjustments as needed," she adds. "This helps you identify where to make changes." ■

Patients using social media to lobby for access to investigational drugs

Safety, hindered drug development are ethical concerns

Social media campaigns have successfully pressured drug companies to approve some requests for investigational drugs for terminally ill patients under expanded access programs (EAPs), but this raises significant ethical concerns, experts say.

"The success of social media campaigns, in most cases, both relies on and fosters public misunderstanding of the limited evidence for the safety and efficacy of drugs early in their development process," says **Steven Joffe**, MD, MPH, vice chair of the Department of Medical Ethics and Health Policy at University of Pennsylvania Perelman School of Medicine in Philadelphia.

One ethical concern is that patients who lack knowledge of how to leverage social media are at a disadvantage. "One shouldn't have to rely on how social media savvy one is, to gain access," says **Peter C. Adamson**, MD, chair of the Children's Oncology Group and Alan R. Cohen endowed chair in pediatrics at the Children's Hospital of Philadelphia.

One argument in favor of expanded access is that patients, with the advice of their doctors, should be able to decide how to weigh the potential benefits, risks, and uncertainty for themselves. "Many argue that it's unreasonably paternalistic not to give patients, particularly those with life-threatening diseases, the right to make these choices for themselves," says Joffe. On the other hand, he says, early access fosters false hopes. This could divert patients from more beneficial treatments, including excellent palliative care, he says.

Here are some other ethical concerns that experts have:

• Investigational drugs may be unsafe for patients. "Compassionate use programs must balance safe and speedy market entry for current and future patients with the immediate needs of patients who may not survive the drug development period," says **Valarie Blake**, JD, associate professor of law at West Virginia University College of Law in Morgantown. Blake is a former ethics senior research associate at the American Medical Association.

"For the individual patient, compassionate use represents hope and a chance at survival, however small and unpredictable," says Blake. "But it may come at a heavy price if the unapproved therapy shortens the patient's life or mars it with harmful side effects."

EAPs are premised on a belief that access to unproven drugs is medically beneficial. "In reality, most drugs put into clinical development never prove safe and effective. Even those few drugs that do prove safe and effective often confer marginal benefits," says **Jonathan Kimmelman**, PhD, associate professor in the Biomedical Ethics Unit at McGill University in Montreal, Canada.

"If the drug is in early phase testing, it's likely that little evidence exists," says Joffe. "Is it reasonable to treat patients

with the drug on the basis of very little evidence?"

Phase I trials usually cannot establish what serious side effects may result from the medication or what long-term consequences of use of the medication may be. Thus, "it is debatable whether any patient can be informed as to the consequences of their actions," says **Steven S. Ivy**, MDiv, PhD, senior vice president of values, ethics, social responsibility, and pastoral services at Indiana University Health in Indianapolis.

• EAPs can threaten clinical trials by giving patients a pathway to avoid trials designed to rigorously evaluate the new drug. "The possibility of eroding the value of research is disturbing," says Ivy.

This is particularly a problem for randomized trials, says Joffe, in which patients have a chance — usually 50% — of not getting the new drug.

"The most important thing in drug development is to rapidly and accurately evaluate the safety and efficacy of a new drug, so that safe, effective drugs can be made available to the public," says Joffe. "Anything that threatens or slows this is bad for the public health."

George J. Annas, JD, MPH, William Fairfield Warren Distinguished Professor and chair of the Department of Health Law, Bioethics & Human Rights at Boston University, says "compassionate use of drugs that have no proven efficacy by patients who are dying and believe — wrongly — that they have 'nothing to lose' by trying them is a major problem for drug companies."

Adamson doesn't see the threat to research as a valid reason for a drug company not to have an EAP, however. "Ideally, you do want patients to participate in clinical trials if they are willing and eligible to enroll. You wouldn't want to see accrual to the trials suffer because of compassionate access programs," he says. "But I'm not aware of any situation like that that has actually happened."

The FDA requires that patients seeking an individual EAP be ineligible to participate in a clinical trial.

The pressure and reputational risk arising from social media campaigns "can be impossible to resist, overwhelming all other legitimate considerations," says Joffe.

Denying a patient's request can become a public relations disaster. "The drug companies haven't been able to take the publicity heat when it is turned up by a social media campaign on behalf of a dying person," says Annas. "The drug company can be made out to look heartless, and even evil."

Compassionate use requests depict science as bureaucratic red tape, adds Ivy. "It is difficult to justify denying even a sliver of hope to the terminally ill," he says. "To watch a patient suffer and die while the possibility of treatment is available seems cruel beyond measure."

Adamson says that clear guidelines are needed on when a therapy will be made available. "If a therapy is truly potentially life-saving, I think the bar to get access to that therapy ought to be lower," he notes. "A lifesaving anti-infective and an early phase cancer drug are not the same."

Advocating for the patient is the physician's job, says Adamson. "Finding a way to allow for realistic hope is part of what oncologists do," he says. "It is not frequent, but there are times when that would include access to a novel agent through an EAP."

The reality is that people will continue to die of potentially curable diseases unless drug companies and others do the research needed to develop cures, says Annas. "Making experimental drugs available outside a clinical protocol simply lengthens this process," he says. "It is, I think, morally sound not to have any exceptions to drug trial protocols."

Some states have passed "right to try" laws allowing terminally ill patients to request experimental drugs and devices after they have completed Phase I testing. "Expanding access to unproven drugs to populations that are otherwise ineligible for trial participation can result in unexpected safety issues," says Kimmelman. "This could derail otherwise promising drugs from being developed."

Right to try laws fail to address a broader issue, says Blake: that the public feels that drugs aren't making it to the market fast enough. "We have to evaluate how much delay we can accept, and at what loss of safety — and what other mechanisms can be put in place to speed drug access for everyone, not just a few," she says.

Right to try laws "make for good rhetoric," says Kimmelman. "But when you look at the science and law surrounding drug development, there is little about such policies that genuinely advance the needs of patients, research systems, or healthcare systems." ■

COMING IN FUTURE MONTHS

- E-model for improving participant safety
- Develop effective staff training tools
- Holding approval parties for exempt and expedited determinations
- How to create a study initiation program

IRB ADVISOR

CME/CE INSTRUCTIONS

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CME/CE QUESTIONS

1. Robert L. Klitzman, MD, author of *The Ethics Police?*, said he brings which of the following "perspectives" to the study of IRBs?

A. A researcher who has dealt with IRBs.
B. A member of a family facing a decision on experimental treatment.
C. The director of a bioethics program.
D. All of the above.

2. The recently issued Common Rule Notice of Proposed Rulemaking would require ethics training for all members of IRBs.

A. True
B. False

3. According to a 2015 study by the Ponemon Institute, what is the primary cause of data breaches in the healthcare industry?

A. Criminal attacks
B. Employee negligence
C. Lost or stolen devices
D. None of the above

4. Which of the following is not a training module for new employees of the Emory University IRB in Atlanta?

A. Expedited review
B. Informed consent and HIPAA
C. IRB of record collaboration process
D. Laying foundation for a full board review

CME/CE OBJECTIVES

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

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