IRB ADVISOR

YOUR PRACTICAL GUIDE TO INSTITUTIONAL REVIEW BOARD MANAGEMENT

JULY 2017 Vol. 17, No. 7; p. 73-84

INSIDE

AHC Media
A RELIAS LEARNING COMPANY

Social Research Exemptions and Common Rule: It's Complicated

By Gary Evans, Medical Writer

As this story was filed, the originally planned finalization and implementation of the revised Common Rule in January 2018 was subject to possible delay along with other pending federal regulations paused for review by the Trump administration.

Perhaps that is just as well for social scientists, behavioral researchers, and their respective IRBs. They find themselves in the midst of a somewhat complicated debate about how and to what extent the Common Rule changes affect or exempt oversight of their endeavors by the Office of Human Research Protections (OHRP).

Some behavioral and social science researchers see a great opportunity. Low-risk social science research that is not federally funded remains exempt from IRB review, and if finalized as currently written it will be much easier to exempt low-risk social science research of all stripes, says **Richard A. Shweder**, PhD, a professor in the department of comparative human development at the University of Chicago.

> "THE OHRP HAS BASICALLY PUT OUT AN INVITATION TO UNIVERSITIES TO FIGURE OUT HOW TO HANDLE RESEARCH THAT IS NOT FEDERALLY FUNDED."

"The OHRP has basically put out an invitation to universities to figure out how to handle research that is not federally funded," he says. "They encourage flexibility and have made it clear that there is no regulation saying how you exempt something, and you can be creative about that. I think there is an onus on all of us to demonstrate that any alternative systems we set up actually produce the right outcome."

Financial Disclosure: Author **Melinda Young**, Medical Writer **Gary Evans**, Editor **Jill Drachenberg**, Editor **Dana Spector**, AHC Media Editorial Group Manager **Terrey L. Hatcher**, Physician Editor **Lindsay McNair**, MD, MPH, MSBioethics, and Nurse Planner **Kay Ball**, RN, PhD, report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

IRB ADVISOR

IRB Advisor,
ISSN 1535-2064, is published monthly by
AHC Media, a Relias Learning company
111 Corning Road, Suite 250
Cary, NC 27518

Periodicals Postage Paid at Atlanta, GA 30304 and at additional mailing offices.
GST Registration Number: R128870672.

POSTMASTER: Send address changes to:
IRB Advisor
P.O. Box 74008694
Chicago, IL 60674-8694

SUBSCRIBER INFORMATION:
Customer Service: (800) 688-2421.
Customer.Service@AHCMedia.com.
AHCMedia.com
Hours of operation: 8:30 a.m.- 6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday, EST.

SUBSCRIPTION PRICES:
Subscription rates: U.S.A., Print: 1 year (12 issues) with free AMA Category 1 CreditsTM or Nursing Contact Hours, $419. Add $19.99 for shipping & handling. Online only, single user: 1 year with free AMA Category 1 CreditsTM or Nursing Contact Hours, $369. Outside U.S., add $30 per year, total prepaid in U.S. funds.

MULTIPLE COPIES: Discounts are available for group subscriptions, multiple copies, site licenses, or electronic distribution. For pricing information, please contact our Group Account Managers at Groups@AHCMedia.com or (866) 213-0844.

ACCREDITATION: Relias Learning is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Relias Learning designates this enduring material for a maximum of *1.5 AMA PRA Category 1 Credits*™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

Relias Learning, LLC, is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Contact hours [1.5] will be awarded to participants who meet the criteria for successful completion. California Board of Registered Nursing, Provider CEP#13791.

This activity is intended for clinical trial research physicians and nurses. It is in effect for 36 months from the date of publication.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

AUTHOR: Melinda Young
MEDICAL WRITER: Gary Evans
EDITOR: Jill Drachenberg
EDITOR: Dana Spector
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EDITORIAL QUESTIONS
Questions or comments?
Call **Jill Drachenberg**,
(404) 262-5508.

On the other hand, some social science researchers see an opportunity missed.

"The 2011 Advance Notice of Proposed Rulemaking [ANPRM] was exciting, in part because of its title, which called for 'reducing burden, delay, and ambiguity for investigators,'" says **Zachary M. Schrag**, PhD, professor of history at George Mason University in Fairfax, VA. "This marked an unusual acknowledgment by regulators that IRB problems start with flawed regulations, not bad acts by institutions. And the ANPRM itself cited important empirical scholarship that demonstrated the arbitrariness of many IRB decisions. Unfortunately, the ANPRM offered relatively timid proposals to address these problems." *(For more information, see related story, page 76.)*

Buck Stops With IRB

IRB Advisor asked **William T. Riley**, PhD, director of the Office of Behavioral and Social Sciences Research at OHRP, if he could clarify some of the revised regulations in this area.

"The revised Common Rule does not specifically exempt behavioral and social science studies, but [it] does expand the research that is exempt from IRB review, some of which clearly relates to behavioral and social sciences research," Riley says. "For example, the revised Common Rule expands the exemption for secondary research — data regulated under HIPAA, conducted for or by the federal government for non-research purposes. Two new exemptions require limited IRB review for secondary data [with] broad consent obtained, and for storage and maintenance of this information."

Riley was the lead author of a recently published article that said; "under the pre-2018 Common Rule, many laboratory-based studies that manipulated an independent variable (e.g., studies of cognition, attitudes, learning) would have required IRB review...but these studies can now be exempt from IRB review."[1]

Riley notes in the paper that "the new and most relevant exemption for behavioral and social scientists is the exemption for research involving benign behavioral interventions on adult subjects, in which the subject prospectively agrees to the intervention and information collection. … The rule defines benign behavioral interventions as 'brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects.'"

Could some of this be interpreted to mean that researchers and IRBs can take the default position that certain categories of social research are exempt?

"This is the exemption for 'benign behavioral interventions' on adult subjects," he says. "It is still standard practice that researchers submit protocols for any research that they believe to be exempt to the IRB for the IRB to determine if it meets the exempt criteria. For these benign behavioral interventions, [that means] if the 'intervention' is brief in duration, harmless, painless, not physically invasive, and not likely to have a significant adverse lasting impact. Therefore, many lab-based studies of learning, memory, attention, cognition, or effect might be exempt if they meet these criteria for being benign, even though these studies may be manipulating an independent variable. In the past, if you manipulated an independent

variable, however benign that manipulation may have been, it would require IRB review — not be exempt."

This exemption also may apply to some systems-level interventions, he adds. For example, an intervention to encourage physical activity in the workplace using signs encouraging people to take the stairs, advocating the benefits of standing desks, or using prompts to remind people to move about after periods of sedentary activity.

"[That] might be considered exempt if the investigator and IRB agree that it meets the criteria [we discussed]," Reilly says. "Exempted behavioral and social sciences research is still 'regulated' by the revised Common Rule. All research involving humans is regulated by the Common Rule and revised Common Rule — it is just that it is regulated by being considered exempt from IRB review. The determination of exempt status by IRBs is typically a rapid process, but IRBs still need to determine that it is exempt."

Bottom line: The buck stops with the IRB. "IRBs are responsible for implementing the Common Rule for their institution, and will provide additional guidance, documentation, and materials to assist investigators in determining which research is exempt from IRB review and the documentation required to request an exemption from IRB review," Reilly says.

Removing the Check Box

Another key development is the elimination of the "check box" formerly used to designate whether the human research rules would apply to trials funded by non-federal sources. In the preamble to the new IRB regulations in the Jan. 19, 2017, *Federal Register,* OHRP states:

"The prior option that enabled institutions with an active Federalwide Assurance (FWA) to 'check the box' is being eliminated. Importantly, institutions could, if they so desire, continue for purposes of their own internal rules to voluntarily extend the regulations to all research conducted by the institution, but this voluntary extension will no longer be part of the assurance process and such research will not be subject to OHRP oversight. We expect this change to have the beneficial effect of encouraging some institutions to explore a variety of flexible approaches to overseeing low-risk research that is not funded by a Common Rule department or agency, without reducing protection of human subjects, thus furthering the goal to decrease inappropriate administrative burdens."

"THE DETERMINATION OF EXEMPT STATUS BY IRBS IS TYPICALLY A RAPID PROCESS, BUT IRBS STILL NEED TO DETERMINE THAT IT IS EXEMPT."

Removing the box is a good idea because, over time, institutions that didn't check it came to regulate research as if they did, Shweder says.

"If you checked the box, you were saying, 'we agree that we will apply these [regulations] to everyone regardless of funding source,'" he notes. "But there was no regulation or compulsion to check the box. Ultimately, a lot of universities stopped checking the box because they reasoned, 'why should we bind ourselves unnecessarily to the OHRP?' But then almost all of them voluntarily continued to apply the OHRP regulations to everybody. So, it ended up that the current situation is one in which almost all universities have, at their discretion, done that. And in doing that, they have not taken seriously the legitimate interest of the many faculties at those universities who do low-risk research in social sciences and the humanities [by] applying [review protocols] which were designed and tailored for research that is not low-risk."

In addition to emphasizing that change in the rule, the onus is on individual researchers — and IRBs, to some extent — to communicate this change and also develop tools or some method of documentation and assessment of the level of risk in order to clarify what is exempt.

"Some kind of simple checklist — as the OHRP has proposed — could be used to exempt out low-risk social science research, with the document being filed within the department with the understanding the IRB can review it if it wishes," Shweder says.

Universities can work out their own ways of doing that. "OHRP has made a proposal, and we put that forward as a perfectly reasonable way to start reforming the system," he says. "The idea is to identify certain kind of cases which are clearly exempt. Have a checklist that a researcher can go down, answering certain kinds of questions — and as a result of that, if it comes out saying you are exempt, you simply submit the checklist to your department. If the local IRB wants to look at that

and say something about that, they can, but the default is that you start doing your research on things that are low risk."

These would be things like interviewing an "autonomous adult" one-on-one with confidentiality procedures in place, he says. Other examples would be performing observations of public behavior or sending out a survey.

"The idea would be you go down a checklist, determine that you are exempt, you start your research, you file, and you probably submit it with a paragraph describing it," Shweder says. "There are a lot of decisions to be made about where you submit, but you could submit it to your department. If you're a student, it could be a thesis proposal committee and you submit it at the time of the hearing. There are lots of ways you could do this that basically involve self-determination."

The matter may end up with policies and protocols developed on an institution-by-institution basis, particularly given the kind of "self-exemption" Shweder argues should be granted to a broad swath of low-risk science research give some IRBs pause.

"Some IRB heads seem to think that you can't have 'self-exemption,' but the OHRP has been quite clear that there is no specific regulation saying how you can go about exception determination," Shweder says. "In any case, I'm not suggesting that everything be exempt. One wants to have [appropriate] human subjects research going on, but it seems to me that there are other ways we can address ethical questions."

For example, Shweder cites the case of a colleague who has been waiting for months to get permission to interview federal judges, who would not seem to meet the definition of an at-risk population.

"Why should that be?" he says. "Why shouldn't a faculty researcher at a university — let's say, who is a legal scholar — be able to have a conversation with any federal judge who is willing to talk to him? Under the Common Rule, even if it was federally funded, that ought to be exempt."

As evidenced by advocacy articles entitled with such phrases as "don't squander this opportunity,"[2,3] Shweder urges researchers to be proactive in clearing the thicket of past protocols and opening social science research to broader exemptions.

"Unless faculties are proactive, this is unlikely to result in big reform," he says. "Entrenched systems are entrenched systems, and all sorts of people either have some stake in keeping them going, or it's just easier to keep them going than to change them. Look, have you read through all those [Common Rule] regulations — it's like a new form of torture. Having people being heroic and willing to make a commitment to reform this is going to be a real challenge. If people are complaining about the current system and they want it changed, the onus is on them to get involved." ■

REFERENCES

1. Riley WT, Akbar F. Revision to the Common Rule: Implications for Behavioral and Social Sciences Research. *Observer* 2017: http://bit.ly/2s0KavB.
2. Shweder RA, Nisbett RE. Don't Let Your Misunderstanding of the Rules Hinder Your Research. *Chronicle Higher Education* 2017: http://bit.ly/2r1GvbY.
3. Shweder RA, Nisbett RE. Long-Sought Research Deregulation Is Upon Us. Don't Squander the Moment. *Chronicle Higher Education* 2017: http://bit.ly/2n6w8VV.

The Big Chill: IRB Critic Says Changes Fall Short

Oversight of social science research still 'arbitrary,' 'inconsistent'

Zachary M. Schrag, PhD, a history professor at George Mason University in Fairfax, VA, is the author of the 2010 book *Ethical Imperialism*, in which he argued, in part, that IRBs have an undue "chilling effect" on research in the social sciences and humanities.

IRB Advisor asked him to weigh in on his past concerns in light of the revised changes to the Common Rule.

IRB Advisor: Discussing the extensive research you performed for your book, you say you found an "arbitrariness and inconsistency [that] is less the fault of any one IRB than a design flaw in the system as a whole." Can you elaborate on your opinion that the 2011 Advance Notice of Proposed Rulemaking (ANPRM) offered "relatively timid proposals" to address these problems?

Schrag: It proposed no mechanisms to require IRBs to base their decisions on empirical evidence, or to share knowledge across institutions. And the 2017 revisions

abandoned one of the boldest proposals from 2011: "a requirement that every institution must provide an appropriate appeal mechanism." The 2017 revisions offer relief to those scholars whose work will now fall wholly out of the scope of regulation. But for those still in the system, I see little protection from arbitrariness and inconsistency.

IRB Advisor: You have mentioned innovative policies at some universities to free social research from IRB entanglements. Could you cite any current examples of these types of policies, perhaps an approach that suggests a way forward for IRBs and researchers in the social sciences?

Schrag: Several institutions, including my own, have explicitly acknowledged that oral history does not require review. The new Common Rule makes this national policy, so I hope that such statements will no longer be necessary once the rule goes into effect.

In 2011, a number of institutions formed the Flexibility Coalition to explore ways that they could offer alternative procedures for research not directly funded by a Common Rule agency, provided their institutions had not promised to regulate all research to Common Rule standards; i.e., had not "checked the box." Now that the new Common Rule eliminates the box, all U.S. institutions will have the option of exploring such procedures. For social scientists, a particularly important step would be allowing researchers to determine if their projects are exempt from review, rather than requiring them to submit applications for approval by IRB staff. Ideally, we can return to the 1980s, when exempt meant exempt.

IRB Advisor: You have made the historical point that the Belmont Report is widely interpreted as applying to "all human subject research," but when consulting the document it actually suggests it does not apply to at least some social science research. Is this a continuing concern, and was there any clarification on this matter in the recently finalized Common Rule?

Schrag: In 1974, Congress passed the National Research Act, which requires funded institutions to establish IRBs "to review biomedical and behavioral research involving human subjects." The same act established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, best remembered today for producing the Belmont Report. But neither the act nor the commission defined "behavioral research," leading to decades of confusion about the scope of the law. The 2017 revision of the Common Rule continues this failure. It claims to apply to "behavioral and social science research," even though the Department of Health and Human Services lacks statutory authority to regulate social science.

IRB Advisor: It is intuitive that human medical research entails risk to subjects and warrants ethical protections and informed consent. What risk or ethical imperatives are at stake in interviews by historians or other aspects of social science research? Is this a case of complete overreach, or are there some principles that warrant oversight in the social sciences?

Schrag: Scholars in the social sciences and the humanities have long recognized ethical obligations, including the duties to seek the truth, to honor promises, and to avoid inappropriate invasions of privacy. Scholarly associations in anthropology, sociology, history, and other disciplines have embraced these obligations in their codes of ethics. Professors have taught them to their students, and universities have censured scholars who breach those codes. But prospective review of research plans — IRBs' primary tool — was developed for quantitative experimentation, and it is not the right tool for ensuring the ethical conduct of evolving qualitative research. ■

The Central IRB Rule Is Still On — For Now

It's becoming more challenging

Soon, all IRBs will need to be ready to contract with central IRBs on cooperative research studies. While many IRBs already participate in reliance agreements, they say it's becoming more complex and will take time and practice to prepare organizations for the big change.

The revised Common Rule, published in January 2017, requires U.S.-based institutions to use a single IRB for NIH-funded multisite studies. Unless President Donald Trump's administration changes or suspends the rule, IRBs and research institutions have until Jan. 19, 2020, to implement the change.[1]

Though the revised Common Rule

states that relying on a single IRB will reduce institutions' burden over time, some say this can be complicated and time-consuming — at least in the short term.[1]

The Emory University IRB in Atlanta has been relying on a single, independent IRB for several years. "We found we were not adding as much value as an institutional IRB, and we wanted to focus more on investigator-initiated studies and federally funded studies," says **Rebecca Rousselle**, CIP, IRB director at Emory University.

Most of the institution's single-study reliance agreements were for data analysis. But as organizations prepare for the Common Rule's 2020 deadline, this is changing.

"For clinical trials involving Emory patients, we've always chosen to review these ourselves until now, and they just require a lot more attention even when we're relying on a single IRB," Rousselle explains.

When the University of Wisconsin–Madison became involved with research with the Inner City Asthma Consortium, the IRB learned that relying on a central IRB requires substantial administrative support and continuous analyses of efficiency and effectiveness, as well as ongoing education and infrastructure support.[1]

The university was asked to be the IRB of record. "We said, 'No, we're not ready yet to handle that. There are many studies with many sites,'" recalls **Brandy Stoffel**, JD, LLM, IRB facilitator for both the University of Wisconsin–Madison and the Inner City Asthma Consortium.

Relying on a single external IRB is challenging, she notes.

"It's hard for people to agree. They're scared and uncertain," Stoffel says. "Because our university already had a relationship with Western IRB, we thought that might be the best place to go."

For all new grants, the consortium relies on an independent IRB of record. Studies that are older and ongoing stay with their local IRBs, she adds.

The same kind of decisions could be made with any independent or central IRB as multisite studies increasingly look for a single IRB of record. The key issue now is how local IRBs can structure their workflow and processes to handle these changes.

"We had a robust process for studies that were reviewed by WIRB that we worked out a long time ago," Rousselle says. "We had certain people in our office who would handle the administrative and local Emory part of study review, and then WIRB would handle the ethical review with our input from the local context."

From that experience, the Emory IRB developed a special process with the National Cancer Institute IRB, which was different from its process with the independent IRB. For example, the National Cancer Institute does not perform a privacy board review, so Emory had to work out a way to conduct that review for those studies, she adds.

Those experiences were positive and worked out well within the Emory IRB's workflow. But beginning last year, things began to get complicated. From working with just a few central IRBs, the institution now works with about a dozen central IRBs. These have included Partners, UCLA, Utah, One IRB, UNC in Chapel Hill, and Children's Hospital of Philadelphia.

"We've gotten a growing number of requests to rely on other single IRBs, and it's taken us a long time to get the agreements reviewed, negotiated, and to process the kind of local context review they request because each of their mechanisms retaining local context is different," Rousselle explains.

The IRB had to develop a system to use its own electronic admission system along with the submission system used by external IRBs.

"We realized we definitely needed a reliance specialist," Rousselle says. "Junior staff can handle the rest of the work."

But a specialist is needed to negotiate agreements and interpret different local contexts. It's challenging to keep track of reporting requirements and standard operating procedures for each of the central IRBs so Emory researchers won't run afoul of any rules, she adds.

"We need to restructure our staff to allow for a reliance specialist to do that work," she says.

Regardless of the revised Common Rule and reliance agreements, local IRBs ultimately will be responsible for any incidents at their institution, Stoffel says.

"I created a chart, saying, 'What does your institution require for reportable event reporting?'" Stoffel says.

The chart shows study teams what to report locally and what to report to the central IRB.

So far, the reliance has worked well, Stoffel notes.

"What's instrumental in the success of this format is having one person — or at least a central location — for communication," she explains. "Anytime any of our coordinators have a question, they can call me."

The central IRB has an online submission system, and it's able to send all approval documents to a distribution list. New sites automatically get all of the approved

documents, Stoffel says.

As IRBs create more reliance agreements, they'll find that their culture will change, she suggests.

"Over the last two years, I've seen culture changes by leaps and bounds," Stoffel says.

IRBs must know which requirements are state laws, versus which are institutional and cultural rules. "Do we have a written policy of how the written assent is obtained, or do we rely on the central IRB to make sure all sites are doing it the same way?" she says. "I went with the most conservative site's consent policy, and we all did that one — everybody agreed to it. It was also difficult to drill it down to one HIPAA template. I wanted it to be consistent across all sites."

Another challenge is that each site has its own approved informed consent language.

"This required language was not actual policy, and it wasn't just culture," Stoffel says.

Stoffel put all required language that is based on policy in a checklist each human research protection program uses.

"We took those and meshed them with NIH language, and we got them all approved," she adds.

As more local IRBs enter into reliance agreements with external IRBs, the logistical details might become less difficult.

For instance, Rousselle has noticed that the agreements seem to be merging toward a common set of terms.

"The more we rely on each other, the more we see these terms and agreements that look good, and the terms seem a little more homogenous, which is good," she says. "We developed a checklist of things we need in a reliance agreement to make sure everything is in there, and it's not as time-consuming now." ■

REFERENCE

1. Federal policy for the protection of human subjects. *Fed Reg.* 2017;82(12):7149-7273.

Watch Out for 'Toxic' Studies When Adding New Hospital to HRPP

Research conduct not in compliance

When WellSpan Health in York, PA, was merging with a community hospital, an unexpected problem came to the attention of the human research protection program (HRPP). It had to do with 17 open studies at the hospital joining the WellSpan Health system.

A study coordinator who worked in a physician's office connected to the hospital approached **Tara Moore**, quality assurance specialist at WellSpan, to ask how research would be handled going forward.

"The ink wasn't even dry on the merger yet," Moore recalls. "We hadn't even discussed a plan. We weren't even aware there was research going on, but because this coordinator brought it to our attention, we started thinking about what we needed to do."

Further investigation revealed the open studies had been reviewed by seven external IRBs. There were only three principal investigators involved, including one who had 13 of the open studies.

That should have been a red flag, but Moore and colleagues believed the IRBs involved had provided enough checks and balances.

"We were familiar with all of them, and we assumed that everything would be fine," she says. "The study coordinator was very knowledgeable, and we relied on her to keep us informed of what was going on with the research, and we still hadn't come up with a plan."

Since WellSpan has an electronic IRB submission system, Moore asked the study coordinator to upload the most recent protocols and informed consent forms into the system. Just loading the informed consents took several months.

"At that time, I was also the IRB coordinator, and I didn't have the time to educate and monitor [the situation]," Moore says.

Then the study coordinator quit only six months after the merger.

"Then, my director said, 'Tara, why don't you go out and check on their paperwork to see what's going on,'" Moore says.

She did, and the hornet's nest burst open.

The following is what the quality assurance (QA) staff learned about the studies WellSpan had acquired with the hospital:

• **Enrollment was counterintuitively high.** Moore and a colleague reviewed one study's

regulatory binders, patient binders, and study documentation. They selected a study with 15 participants, which was a large number for a study in a small, rural hospital to have recruited.

The original study coordinator emphasized the high enrollment and how much money it brought into the hospital.

"She put an emphasis on that, and it was uncomfortable," Moore says.

• **There were consenting and other errors.** "When we started looking at the registry, the documentation was atrocious," Moore says. "Documentation was not anything like we expected."

The documents contained consenting errors and inclusion criteria mistakes. Subjects who should have been excluded were enrolled. "We were overwhelmed by the number of errors," she notes.

There was an unlocked drug closet. An expired study drug was sitting on the floor. Informed consent forms had words crossed out and patient signatures in the wrong places. The study coordinator and research nurse signed and dated in the wrong places. However, none of the findings indicated any patient harm.

"We found that monitoring visits occurred and discrepancies were noticed by the monitor, but there was never a follow-up and no documentation of the site correcting its errors," she explains. "There was no documentation that the monitor reminded them."

Moore found it difficult to understand why sponsors and IRBs allowed the study to continue despite the site's flaws. She learned that the principal investigator was responsible for the conduct of the study.

• **An independent audit was needed.** "We wrote a report and sent it to my supervisor, who escalated it to hospital leadership," Moore says. "They put enrollment on hold on all open studies and said, 'We're going to figure this out.'"

Moore had too many responsibilities to take on the work of auditing the studies, so the organization contracted with an outside expert.

Two auditors were onsite for 4.5 days, interviewing staff, reviewing policies and procedures, and reviewing 11 research projects and study financials. They wrote a summary and recommendations.

• **WellSpan notified stakeholders**. "We were responsible for the conduct of research, so my director sent a notification letter to the seven external IRBs and study sponsors and said, 'FYI, the studies are on hold while WellSpan completes an audit of each of the studies,'" Moore says.

Being on hold meant the studies were suspended to new enrollment. Updated information could be added to the studies, but everything else was on hold, and study participants were notified.

The study departments/sites had to write corrective action plans for the problems discovered by the internal audit.

"For instance, the patient/subject signs a consent and signs in the consenter's spot," Moore says. "When we found things like that, we wrote a note to the file and attached it to the file, saying it was noticed on this day that the subject signed this line. Consent occurred and the subject agreed to be in the study, but it was verified that the subject signed it on an incorrect line."

The study staff needed education on WellSpan's research policies and procedures and human research protection regulations.

Also, the IRB and Moore spoke with department leadership about the physical needs of studies, including the need for drug closets to be double-locked, and separate copier/scanner equipment.

"We provided a lot of information to them over a six-month period to get their studies up and running again, and we closed out the studies we could," Moore says.

For instance, some studies were in long-term follow-up or data analysis, and these could be closed.

"Everyone was overwhelmed," Moore recalls. "At the same time this was going on, the principal investigator who had the most open studies left the system, as well."

The department hired a new doctor who was interested in becoming a principal investigator. The remaining ongoing studies, which were still on hold, were transferred to the new physician.

"The department leadership opened up one study at a time," Moore says. "We went in, educated, cleaned up everything, and did one study at a time."

• **The FDA got involved.** "They announced a full FDA audit in December 2015," Moore says. "A research nurse spent a lot of time with her."

Ultimately, the FDA audit held the principal investigator, who had left, responsible for the problems, Moore says.

"The auditor said there was clear evidence that once WellSpan came in, there were improvements, and WellSpan did the right things and took the right action," Moore says.

The experience with the hospital's problematic studies was an eye-opening experience for Moore and others at WellSpan.

"Moving forward, we're very proactive," she says. "We had another hospital join our system within three

months of the merger, and they had only one study that was open."

Moore visited the hospital's study staff, made introductions, and made sure documentation was correct.

"I talked to the principal investigator and made sure everything was being followed as far as rules and regulations," she notes.

The standard practice now is to meet and greet research staff at newly merged hospitals and provide them with a minimal education. The staff is given time to adjust to new requirements and changes, and the IRB monitors the progress.

"We look at things, and it's very informal and casual, and what we hear is positive feedback," Moore says. "They appreciate this, and they've embraced the research efforts."

Among the lessons learned is that a research institution cannot assume everything is perfectly fine with a study just because the study was reviewed by an external IRB. Every study and research team's work should be monitored continually to prevent the problems WellSpan found with the newly merged hospital's open studies.

"It was a very, very interesting experience — and one I hope never to have to repeat," Moore says. ■

Researchers Develop Three Strategies to Shorten Informed Consent Forms

Stakeholders liked change, study finds

Many in the research world admit that informed consent forms are too long. Yet, it's difficult to find agreement on what should be shortened or cut.

One new study has an answer that might appeal to most people who work in human research protection: eliminate repetition.[1]

"One of the main findings from our study is that consent forms are highly repetitious. The same information is presented over and over again," says **Amy Corneli**, PhD, MPH, an assistant professor at the Duke Clinical Research Institute at Duke University School of Medicine in Durham, NC.

Stakeholders were asked to evaluate various informed consent forms. The forms ranged from 16 to 21 pages with 429 to 523 sentences. In each, study procedures was the longest content area, and risks and confidentiality was second.[1]

When investigators sought input on how to shorten the forms, they heard that people wanted the repetition reduced. Respondents also said the forms were too detailed and laborious.[1]

The investigators developed the following three main strategies:

1. Group study procedures by frequency. "Right now, in consent forms, investigators often list each study procedure that happens at every study visit," Corneli says.

So if blood is drawn at weeks 1, 4, 8, 12, 16, then they'll list "we will draw X amount of blood" five times.

"For informed decision-making, it likely doesn't matter whether something will be done at week eight or 12," Corneli says. "Potential participants likely just want to know that they'll have blood drawn and how often it will be done."

For instance, the informed consent form could read, "At most or at all of these study visits, we will…" and then list items, such as ask questions about the participant's health, draw blood, collect a urine sample, etc. It also could describe what might happen at some of the visits.[1]

Since some research participants will want to plan their visits and know whether and when they'll have invasive procedures, the informed consent can include this detailed information in a diagram. "The left side can have all study procedures, and columns can be for each week's visit," Corneli says.

This doesn't have to be part of the informed consent form, but a table they can have as a reference.

2. Use appendices (if allowed). The study explored the use of appendices to provide participants with information that was not critical for informed decision-making, but which would be nice to know.

Tables, diagrams, and charts — such as the idea of a chart that outlines procedures at each visit — could be part of an appendix, Corneli says.

"We explored whether people would be accepting of putting detailed information in appendices, and, overall, they were supportive," she adds.

However, the revised Common Rule does not support appendices in the informed consent document, Corneli notes.

Key information must be at the beginning of the informed consent document, and detailed information follows that information, she says.

Even if implementation of the revised Common Rule results in a ban on appendices in informed consent, IRBs and study sites still could include tables and charts as separate information.

"Make it clear it's not new information," Corneli suggests.

Instead, the tables and charts could provide additional details on the same topic to help participants prepare and plan for their visits, but not to aid them in their decision-making process about study participation, she adds.

3. Eliminate duplicate side effects. This strategy is to list side effects once, instead of listing them under each medication included in a trial.

"List all the side effects of each study medication, and remove those listed twice so participants are not distracted by listing the same side effect over and over," Corneli suggests.

An informed consent form could read, "You will be randomly assigned one of these study drugs. Here are all of the possible side effects," she says.

This strategy made a surprising difference in the word count in the study medication section of one informed consent form, cutting it from 944 words to 622 words. Also, the change was approved by most respondents, who said it made the side effects simpler and easier to understand.[1]

These three strategies were approved by greater than 90% of stakeholder respondents in the study.[1]

Researchers mainly looked for ways to shorten the informed consent form without removing information that some IRBs and sites would find necessary. The solution was to focus on repetition.

"Removing repetition to shorten consent forms is easier than saying, 'This information is not needed,'" she notes. "There's a strong consensus for these three strategies, and there's a really high consensus to reduce the length of consent forms." ■

REFERENCE

1. Corneli A, Namey E, Mueller MP, et al. Evidence-based strategies for shortening informed consent forms in clinical research. *JERHRE*. 2017;12(1):14-25.

New Report on Research Integrity: Institutions Also Play a Role

It's not just individual researchers who need to support scientific integrity. Institutions and environments also play important roles, says a new report from the National Academies of Sciences, Engineering, and Medicine.[1] The report, *Fostering Integrity in Research*, says that detrimental research practices should be understood to include not only actions of individual researchers, but also irresponsible actions by research institutions and journals.

The report recommends the following:

- research institutions go beyond simple compliance with federal regulations;
- senior leaders at each institution — the president, other senior executives, and faculty leaders — should be actively engaged in these tasks;
- whistleblowers who raise concerns about the integrity of research are protected, and their concerns addressed in a fair, thorough, and timely manner;
- institutions encourage routine disclosure of all results, including negative findings.

C.K. Gunsalus, a member of the committee which developed the report, doesn't expect any of these recommendations to elicit controversy. "The recommendations are generally evidence-based and make sense in the environments in which we operate," she says.

Gunsalus, director of the National Center for Professional and Research Ethics at University of Illinois Urbana-Champaign, adds, "The central observation that we must look at environments as well as people, and assess them, is a central finding I hope gets traction."

The report recommends that a Research Integrity Advisory Board be established. Gunsalus says this will take time and work to accomplish. "It's been recommended before, and has so much to offer. I hope that it gets off the ground this time," she says.

The report notes that no such platform exists currently to foster research integrity at a national level. **Barbara Redman**, PhD, RN, an associate of the Division of Medical Ethics at NYU School of Medicine, says, "I am hopeful that this time, such a board will be established, and can vigorously work through current problems with research integrity."

More information is needed on environmental pressures that could lead to detrimental research practices. "We

have to learn more, and apply what we learn to improving the 'nudges' our environments provide to make good choices," Gunsalus says.

Redman, an external reviewer for the report, notes that the current situation is referred to as "a serious threat" to the scientific enterprise. "I was heartened to see the scientific community coming to grips with its problems in quality of science," Redman says. However, she says, there is a "long road of work ahead" to determine the following:

- the level of reproducibility that should be expected;
- how common standards of quality can be extended across the commercial and academic settings, regardless of funding source;
- whether it's misguided to believe that whistleblowers are sufficient to detect research misconduct despite strong incentives against speaking out;
- how research integrity requires reforms across the entire system of science (institutions, publishers, funders, as well as individual scientists);
- the degree to which science can be self-correcting, or requires different or more rigorous regulation.

"It is important to note that this is an international problem," says Redman. "Countries vary widely regarding the attention they are giving to the cluster of issues under the umbrella of research integrity."

Zubin Master, PhD, associate professor at Albany (NY) Medical College's Alden March Bioethics Institute, says the old way of thinking is that a morally corrupt individual was solely to blame for research misconduct such as fabrication, falsification, or plagiarism.

"People have now started to move away from that," says Master. "Of course the individual has responsibility, but research institutions are also accountable." In Master's view, this includes not just the academic institutions where the researchers are actually housed, but also major research funders like the National Institutes of Health (NIH).

"The institutions to some degree are influencing the research environment and how scientists conduct their business," says Master. "They are either promoting, or not, a culture of research integrity."

Many researchers are under a great deal of pressure to secure external grant funding to pay part or all of their salaries. Research institutions benefit from the indirect costs from these grants — and from cheaper trainee labor. "We are in a hypercompetitive environment. Trainees find it difficult to find faculty appointments, and scientists have a very low success of getting NIH grants right now," Master explains.

Many research institutions have had recent scandals involving research misconduct, with considerable repercussions including damaged reputations.

"Some research institutions are very good at handling issues, while others are not," says Master. Some take action only after a particularly egregious incident gets headlines. "They don't want embarrassment. The typical approach has been to eject the bad apple — firing or severely reprimanding the researcher," says Master.

Institutions historically have lacked well-studied tools to assess the research environment. A recently developed tool, the Survey of Organizational Research Climate (SORC), evaluates researchers' views on a range of issues involving their institutional climate.[2]

While SORC is a relatively new tool, says Gunsalus, "it's been used at a number of large universities across the U.S., including several Big 10 universities, and in a nationwide study in the VA research service."

It's problematic that some institutions provide minimal education on research integrity, says Master. "We need to shift our mentality away from compliance, and actually promote a culture of research integrity," he says.

Other institutions invest a great deal of educational resources in the hopes of preventing misconduct. "Whether education influences ethical behavior, we really don't know," says Master. "The instruments to actually test whether people are behaving ethically are only also starting to be built and used."

In his own research, Master is focusing on the effect authorship misallocation has on other, possibly more egregious, research misbehaviors. "In the work we've done, we're seeing that authorship might have a bigger impact than we realized. People who were slighted when it came to authorship may be more inclined to cut corners or seek retribution in the future," says Master.

Master says that much more information is needed. While the NIH funds bioethics research involving human subjects or genomics, there is no dedicated funding available for studies looking at the research integrity climate.

"The NIH should be funding research on research integrity," says Master. "They don't have any funding devoted to that, and they should make such funding available for this important research." ■

REFERENCES

1. The National Academies of Sciences, Engineering, and Medicine. Fostering Integrity in Research. Washington, DC: The National Academies Press, 2017.
2. Martinson BC, Thrush CR, Crain AL. Development and Validation of the Survey of Organizational Research Climate Development (SORC). *Sci Eng Ethic*. 2013; 19(3):813–834.

CME/CE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.
2. Log on to AHCMedia.com, then select My Account to take a post-test.
3. Pass the online test with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the test, a credit letter will be emailed to you instantly.
5. Twice yearly after the test, your browser will be directed to an activity evaluation form, which must be completed to receive your credit letter.

CME/CE QUESTIONS

1. **According to William Riley, under the new Common Rule revisions, many laboratory-based studies that manipulate an independent variable:**

   a. will not be exempt from IRB review.
   b. must expand informed consent requirements.
   c. can now be exempted from IRB review.
   d. have shown a high level of researcher bias.

2. **Which of the following meets the OHRP criteria for a benign behavioral intervention?**

   a. Brief in duration
   b. Painless
   c. Not physically invasive
   d. All of the above

3. **The revised Common Rule, published in January 2017, requires U.S.-based institutions to use a single IRB for cooperative research that takes place where?**

   a. In Europe and Asia
   b. In the United States
   c. In North America
   d. All of the above

4. **A new study by Duke University researchers found that which strategy works well to reduce the size of informed consent forms?**

   a. List all possible adverse events in an appendix.
   b. Eliminate institutional IRBs' boilerplate language.
   c. Eliminate repetition by listing study visit procedures and potential adverse events only once.
   d. All of the above

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.