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INSIDE

RELIAS MEDIA

Study: Minorities Remain Underrepresented in Cancer Trials

IRBs, PIs can work toward diversity

By Melinda Young

A study of clinical trials involving cancer drugs over the past decade shows that the problem of studies enrolling too few racial and ethnic minorities has not improved, although the issue has been raised publicly for years.[1]

Investigators examined more than 200 trials that included 112,000 patients, and compared study participants' demographics to the general United States cancer population. They found African Americans were enrolled in cancer drug clinical trials only about one-fifth as much as expected, says **Jonathan Loree**, MD, assistant professor at the University of British Columbia in Vancouver. Researchers found that black and Hispanic groups were underrepresented consistently in trials when compared with their burden of cancer incidence.[1]

"We think the underrepresentation is multifactorial," Loree says. "The reason for a disparity might vary with each system. In the U.S., the problem is a lack of access to healthcare."

> "THE REASON FOR A DISPARITY MIGHT VARY WITH EACH SYSTEM. IN THE U.S., THE PROBLEM IS A LACK OF ACCESS TO HEALTHCARE."

In Canada, some underrepresented minority groups, such as Native Americans, live farther away from clinical trial sites. This longer distance could be a barrier to study participation, he adds.

Investigators examining representation of minorities in studies had hoped enrollment of racial and ethnic minorities had improved over the decades, but there was no improvement, Loree notes.

"Minorities still are underrepresented," he says. "There have been statements from the FDA and other groups

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that this is a priority to address, but over the past decade, we didn't see any improvement, which suggests we haven't done enough to address the problem."

Respect and trust can affect recruitment of underrepresented minorities. When these are lacking, recruitment often is lower. *(See article on researchers building trust in minority communities, page 16.)*

"We spend a lot of time in bioethics thinking about respect for persons, but we don't have a good way to put that into practice," says **Stephanie Kraft**, JD, assistant professor, bioethics and palliative care at Seattle Children's Hospital and Research Institute.

"A lot of people are paying attention to minority recruitment now," Kraft says. "It's important scientifically and from an inclusion perspective, particularly in implementation science and making sure healthcare is getting out to everybody."

Demonstrate Respect

Researchers need to find ways to demonstrate respect to underrepresented minorities to encourage research participation, according to Kraft's recent study.[2] Another recent study revealed that researchers could increase Hispanic recruitment 15-fold by sending someone into Latino communities to educate people about the study's topic of Alzheimer's disease. The recruitment strategy used brief, in-person, culturally tailored educational sessions in senior centers.[3]

"I was testing a strategy to increase participation of Latinos in our research study," says **Jaime Perales-Puchalt**, PhD, MPH, assistant professor, University of Kansas Medical Center and the University of Kansas Alzheimer's Disease Center. "We wanted to recruit 30 Latinos, and we did this quicker than I expected," he says.

In the first six years of a longitudinal study, researchers recruited only two Hispanic participants. One challenge was the low Alzheimer's disease literacy among the population, Perales-Puchalt notes. Conventional recruitment messaging might not work, whereas visual messaging could succeed.

"For example, every message that I create is pictorial," Perales-Puchalt says. "There is a picture that explains what I'm saying, and the words are short and simple, instead of overly scientific."

Educational sessions with potential participants were interactive. "When I give this talk about Alzheimer's disease, I encourage people to ask me questions as much as possible," he says. "That's a great way to know if people understand what I'm saying."

Using Perales-Puchalt's strategy, researchers recruited 30 Latinos within one year, from November 2017 to August 2018. This great improvement was not easy. Perales-Puchalt created a 45-minute PowerPoint presentation, in Spanish, about aging and dementia. He gave the presentation to Latino communities, educating people about the disease and the clinical trial.

"I want to emphasize that it's not translation, it's application," Perales-Puchalt says. "I'm not just translating this information. I've gone into the community, visited community centers in Kansas City to talk with professionals who serve the Latino community," he explains.

"I've gone over the information, slide by slide with them, getting their feedback to make it as user-friendly as possible." This careful process took him five sessions to complete, he adds.

Breaking Structural Barriers

Investigators who recruited African American women at federally qualified health centers (FQHCs) ran into some structural barriers in enrolling this population, says **Jeanne M. Ferrante**, MD, MPH, professor of family medicine and community health, and director of the New Jersey Primary Care Research Network, Rutgers Robert Wood Johnson Medical School in New Brunswick.

"The centers did not have adequate staff, space, and time to help with recruitment," she says. "At many clinics, they were busy and didn't have extra examination rooms. When we wanted to interview a patient, we would have to wait for a room to open."

In some cases, researchers would find a patient willing to be enrolled and go through the informed consent process, but the person would have to wait 30 minutes for a room where they could speak privately, Ferrante explains.

"Especially when you are at a federally qualified health center that is crowded and busy, you need to speak ahead of time with clinic administrators to identify which office space is available and the optimum time to be in those clinics," she says.

Trust is another barrier. Ferrante recalls a study in which African American women were reluctant to sign the consent form. "They said, 'No, I don't want to sign my name or anything.'"

It also helps to employ a community member on the research team. This would be someone with whom participants are familiar, or who has already enrolled in the study, who could talk about the study with them, Ferrante says.

"In other studies, we've found that it helps if we hire African American recruiters," she says. "In this study, recruitment took longer than we anticipated. We had to recruit more staff, and didn't have the opportunity to hire just African American women."

> "WE SPEND A LOT OF TIME IN BIOETHICS THINKING ABOUT RESPECT FOR PERSONS, BUT WE DON'T HAVE A GOOD WAY TO PUT THAT INTO PRACTICE."

Ferrante lists these additional methods to improve recruitment:

- Include pictures of the minority group on fliers;
- Keep the informed consent text at a sixth-grade reading level;
- Read the informed consent document to participants, as needed;
- Make language in the consent form more patient-friendly;
- Provide small financial incentives, such as a $25 gift card, to compensate participants for their time.

To recruit in some underrepresented minority communities, researchers need to build partnerships with the community prior to recruiting participants for a study. For instance, in recruiting Latinos for the Alzheimer's disease enrollment study, researchers built a partnership with the centers that serve Latinos, Perales-Puchalt says.

"That's the first thing that worked," he says. "Go where the community is, instead of having them come to you. That's what I've done." Perales-Puchalt met potential participants at their community centers, and this also resolved the transportation barrier.

IRBs and research communities need to learn more about how to increase underrepresented minority enrollment. Studying this issue can help, he says. "We have a focus group to talk about best practices in enrolling Latinos in Alzheimer's research," he adds. ■

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Building Foundational Trust Among Minority Populations Is First Step

Lack of trust is key barrier

By Melinda Young

Lack of trust is an important issue affecting recruitment of underrepresented minorities in research studies.[1] When there is little trust for medical and research professionals among a particular underrepresented minority group, it is important for research organizations to build a foundation for trust before recruiting people for a particular study, says **Jaime Perales-Puchalt**, PhD, MPH, assistant professor at the University of Kansas Medical Center and the University of Kansas Alzheimer's Disease Center.

Trust issues can be ingrained in the culture, or based on individuals' personal experiences in healthcare. For instance, Perales-Puchalt encountered one research participant who did not trust a study's recruitment process because he thought it was a scam.

"He had experienced miscommunication with the Affordable Care Act in the past, where the thought he didn't have to pay for the insurance, but had to pay, eventually," Perales-Puchalt explains.

Meeting underrepresented minority populations in their communities helps build a foundation of trust. "It's very important to not just partner with community leaders, but also to assess the needs of the community," Perales-Puchalt says.

The foundation of building trust is based on the concept of respect for persons, says **Stephanie Kraft**, JD, assistant professor of bioethics and palliative care at Seattle Children's Hospital and Research Institute.

"We spend a lot of time in bioethics thinking about respect for persons, but we don't have a good way to put that into practice," Kraft says. "My research is to better understand how to demonstrate respect for participants in a meaningful way to increase trustworthiness of researchers and research teams."

Investigators think about ethical research, but they might not be empowering and supporting their research staff and recruiters in the ethics of research and study recruitment to foster inclusion and diversity, she says.

"One thing we're hearing from nearly everybody is that the way research teams talk with people has a big role in whether they feel respected," Kraft says. "On the one hand, that seems obvious, but it also illustrates how important it is that we focus on the role of research staff and recruiters out on the ground, having conversations with folks."

In a recent study, Kraft found that operationalizing respect and making it meaningful is critical to successful recruitment and retention. The study showed that demonstrating respect for persons in the recruitment and informed consent processes helped increase diversity in research. Additional research is needed to evaluate how people from diverse backgrounds define respect for persons, and what investigators could do to make them feel respected.[2]

"I asked people about their perceptions of trust and respect in both research and general healthcare," Kraft says. "I assumed we would hear people were more trusting in healthcare than in research, but I heard answers that surprised me."

When people discussed their impressions of research, they talked about the of the respect study for which they were recruited. They had a good experience with that, she explains.

"They said, 'So far, I feel respected, and it's good,'" she says. "But a lot of folks had examples of times in the healthcare setting when they might not have felt respected, or when they had other concerns about how they were treated."

Kraft is analyzing data from the research, but the initial findings have raised more questions about how researchers can do a better job of demonstrating respect of participants: "What are those experiences in the healthcare setting that influence what people think about research, and how can we do a better job?" she asks. "It's not just about treating people with respect in the research process, but also about how to treat people, more broadly speaking, with respect in the primary care setting."

Some people endured specific negative experiences in healthcare, but there also are broader issues in how the healthcare system treats people in certain minority groups. That problem is more difficult to fix, Kraft says.

"Everything we do as researchers and clinicians is within the context of the bigger system," she explains. "We need to take a bigger-picture

perspective as we think about how to navigate some of these issues."

It is difficult to tackle systemic issues related to trust among a minority community, but research organizations can help recruitment through simple measures, such as simply recognizing and listening to potential participants, Kraft suggests.

"That's the No. 1 thing we've heard from people about showing respect," she says. "That's very doable for every researcher and every physician." ■

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Pregnant Women Face 'Default' Exclusion From Clinical Trials

IRBs should reconsider inclusion in light of Common Rule change

By Gary Evans

With the revised Common Rule removing pregnant women from the list of "vulnerable populations" in 2019, it is time for IRBs to reconsider the default exclusion of expectant mothers from clinical trials, a bioethicist argued in a new paper.[1]

Author **Pamela Payne**, BSN, MSN, NP, is a maternal-infant nursing instructor at the Patricia A. Chin School of Nursing at California State University in Los Angeles. The Common Rule change reflects the concern that a "paternalistic view" of pregnant women denies their participation in trials that may be beneficial for mother and fetus, she says. Although the revised rule "permits pregnant women to participate in clinical research under appropriate conditions, some research sponsors, researchers, and IRBs may still be reluctant to allow them to do so," Payne emphasized in the paper.

The current situation can be traced to birth defects from the sedative thalidomide in the mid-20th century, and the cancer risks of the synthetic estrogen diethylstilbestrol that arose in the same period.

"[Those incidents] made people very reluctant to include pregnant women in clinical drug trials," Payne tells *IRB Advisor*. "Certainly, no one in the drug industry wants the bad publicity, or to harm mothers or their children. But it was that and other smaller studies and issues that just made it a little bit easier to not include pregnant women at all."

While pregnant women are no longer considered a vulnerable population, there are longstanding criteria in the Common Rule that IRBs should consider before including them in a clinical trial. Ethics panels should eview these criteria and consider whether pregnant women could be included in research, Payne says.

"We are just asking them to think about them," she says. "My concern is that because it is a little complicated, and IRBs are under a lot of strain and have a lot of work to do, that rather than look through the list of criteria they have said, 'Let's not even deal with it.'"

If there is a risk to the pregnant woman or fetus, they would not be included in a trial, Payne emphasizes. But she is trying to reopen this issue, and urges IRBs to hold these discussions.

Payne has four recommendations to assist IRBs in reconsidering inclusion of pregnant women in clinical trial research while providing appropriate protections:

- Include experts in obstetrics and maternal-fetal medicine as regular IRB members;
- Interpret traditional ethical principles in a manner that justifies, rather than presumes, exclusion;
- Incorporate the regulatory conditions of subpart B of the Common Rule to justify the exclusion of pregnant women;
- Consider additional safety monitoring to ensure that regulatory protections are met.

"Maybe doing these trials would require more frequent reporting of any adverse events, and seeing how participants are faring," she says. "If harm is developing, we could cut it off early."

IRB Advisor asked Payne to comment further on this issue in the following interview, which has been edited for length and clarity.

IRB Advisor: Will removal of pregnant women as a vulnerable population open a new avenue for revisiting this issue?

Payne: Yes. It acknowledges the fact that the change in terminology is important. "Vulnerable" implies that they are not in a position to be able to decide for themselves, or that they are more at risk for exploitation because we include children in vulnerable populations. The Common Rule also lists prisoners and military personnel because of the potential for undue influence and coercion to participation. [For a pregnant woman] I think it somewhat discounts her decision of whether she believes [a trial] would be beneficial to her and her child by just assuming that she needs extra protections. I am not saying we should take away protections; it is important, and they do have a different situation. But I believe that the Common Rule precautions already allow for judging whether a particular trial is appropriate.

IRB Advisor: You note that excluding pregnant women raises ethical issues regarding the principle of justice in the Belmont Report.

Payne: The principle of justice says that people deserve to be treated equally and appropriately. Excluding any particular group on sort of a knee-jerk reaction is not fair or just. As a clinician, I practiced as a women's health nurse practitioner in prenatal care. We were always concerned with what to do with women who had pre-existing health issues that required treatment — [conditions] that could affect the fetus if they were not treated properly. If something developed during the pregnancy, sometimes we didn't know what was safe to use and what wasn't. A lot of times, we would either use something and cross our fingers, or not use something that could have been of benefit. Because of this, there is a growing consensus among a lot of clinician groups and even the NIH that we are not benefiting pregnant women [by excluding them from research].

IRB Advisor: Does the default to protection also mean researchers are unlikely to discover therapies of benefit to women?

Payne: Most of the information on the harmful effects of drugs in pregnancy is essentially anecdotal. If you use a medication in pregnancy with one of your patients, and she or the fetus suffer an adverse effect, then you report that to a drug registry at the FDA. That's how we have been gathering all this data over time, but it is not really a good, sound scientific evaluation of risks and benefits.

Obviously, we are not asking pregnant women to participate in all drug trials. It is only those [drugs] that would specifically be of benefit to a pregnant woman or the fetus. Given that women's bodies change so dramatically during pregnancy, the metabolic environment is entirely different. For example, a woman was taking medication for a thyroid condition. That may need to be changed perhaps to be an efficacious dose during pregnancy, because of the metabolic differences. That [dose adjustment] might be helpful for her fetus.

IRB Advisor: You also recommend that IRBs add pregnancy experts to their panels?

Payne: Yes, IRBs should consider having an obstetrician or a maternal/fetal expert as a routine member of their clinical staff, as opposed to someone you call on when you are thinking about conducting a trial that might include pregnancy. I think someone being there all the time allows the expert to become really familiar with the decision-making process of the IRB, and how you apply ethical analysis. They would advise the IRB appropriately, saying, for example, "This medication is too much like this other medication that we already know is dangerous." Or, "This is something that we really do need to know about efficacious dosing changes." In light of the changes with the Common Rule, perhaps some of the larger IRBs may be more inclined to this.

IRB Advisor: What about issues of informed consent?

Payne: You can't separate the mother from the fetus, and she is the one making the decision because they are one unit. Her informed consent also consents on behalf of the child. It is very similar to the way that parents give permission for their child to receive a vaccine, for example. The child does not understand well enough to consent, so the parents do so for their child.

IRB Advisor: What about the fetus and the ethical principle of autonomy?

Payne: Respect for a person's autonomy also is respect for the fetus. Who is in a better place to respect the fetus than the mother? She is the one who is invested in the health of this child, so her viewpoint should carry more moral weight than simply saying, "We don't want to harm the fetus." She doesn't want to harm it, either.

IRB Advisor: You mention that researchers have been reluctant to perform these studies. Is that another mindset that has to change?

Payne: Yes, and it is going to take some education. I think some of the education may begin with an IRB

being at least willing to entertain a research proposal. I think a lot of researchers and drug sponsors have just [felt] that IRBs have been historically reluctant to include pregnant women, so why go to all the work of preparing a proposal? Part of the education that would be involved could include [an explanation] that these are our guidelines should you choose to propose a research study that might include pregnant women. ■

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IRB Teaches Research Teams How to Write Key Informed Consent Information

By Melinda Young

The revised Common Rule charged IRBs with writing concise and focused informed consent information. The challenge for IRBs is how to achieve this.

The Colorado Multiple IRB (COMIRB) at the University of Colorado has found a novel solution. The IRB trained staff on how to write key information consistently. They also added these tasks to the IRB staff's workload without delaying IRB reviews, or having to use additional staff resources.[1]

"It started with IRB leadership writing key information," says **John C. Heldens**, RAC, CIP, director of COMIRB at the University of Colorado Denver Anschutz Medical Campus. "Once we set our boundaries and decided what would be included in key information, and what would be excluded, we documented those as an internal guidance document. We trained IRB managers, who train IRB staff, to read the consent form, look at the protocol, and draft a key information system."

The process was time-consuming at first, but has become easier and faster, he notes. "The goal is to keep it short, to one page," Heldens says. "By and large, we have achieved that."

Another chief goal was to keep the information meaningful, providing the subject with a high-level summary to read before perusing the entire informed consent document.

"When they read the first page, they have a pretty good idea of what the study is about," he says. "There are more details in the rest of the informed consent form, but we think this change has been successful."

Consistency is a third major goal. "We also felt that consistency was important," Heldens says. "I'm not sure it's critical, but whether we have a consent form from oncology, cardiology ... key information is consistent."

This is how the IRB created the key information page:

• Engage IRB staff, chairs, and campus leaders. The IRB's professional staff created the key information with input from IRB chairs and campus leadership, he says.

IRBs review thousands of consent forms, so they can rely on their experience and expertise in writing or approving a key information page, Heldens notes.

"There's a learning curve, but it's not as steep as you might think," he says. "We also asked for input from IRB community members for the project. We wanted feedback from previous patients and research participants."

• Include relevant and essential information. The key information includes a preamble that describes the study. It also should include brief sections on the study's purpose, procedures, risks, benefits, and alternatives.

"We made a change to our consent form to put the principal investigator's contact information on the first page," Heldens says. "We didn't have that number listed before, but we considered who people would go to for questions on the key information. We addressed that by putting the investigator's number on the front page."

Key information includes a broad description of procedures. "In the context of a clinical trial, there may be dozens of screening procedures, and we don't describe all of those," Heldens explains. "We say, 'You'll have a screening visit, and if you're eligible, this is what will happen.' But we don't describe the fairly routine procedures."

The description of procedures might look like this: "First, you have a screening visit. Second, if you're eligible, you might be assigned to one or two visits," he says.

"We don't go into details about screening visits," Heldens adds. "What we want to do is get to the point right away."

• **Summarize risks.** The idea is to summarize overall risks, as opposed to breaking down the risks by drugs or devices.

"List the most important risks, which are the ones that are serious or common," Heldens says.

If death is a risk, it is part of key information. "You could have a page of risks for each drug in oncology research," Heldens says. "Those risks are identical from study to study, so we made a good effort to summarize the risks." Sometimes, it might be appropriate to break out risks by a drug or device, but that can be part of the decision-making process, he adds.

They also decided that costs are not part of the key risk information, unless there is something in the trial that will significantly increase a participant's cost, Heldens says.

"We also decided that confidentiality is never part of the key information because it's never a real risk," he explains. "By and large, investigators do a good job of protecting confidentiality, so it's rarely a real risk of subjects."

• **Include benefits and alternatives.** "These typically are a boilerplate statement that participating in the study involves studying a treatment and a person may or may not benefit by participating in research," Heldens says.

"If the study is not intended to benefit the subject, then we say that," he adds. "We keep this section short."

Alternatives to participating in the study are listed, if any.

• **Describe randomization.** The key information page informs participants that they might or might not receive the experimental drug or device. The decision is made randomly, Heldens says.

"We say, 'You'll be assigned to one of the following two groups, and you don't get to decide,'" he explains. "If the study is blinded, then you won't know which group you're in."

In describing randomization, the key information emphasizes that the study participant does not have a choice on whether they receive the experimental treatment.

Detail the Study Scope

• **Describe the scope of study the activity.** "We will summarize the number of visits and how long you'll be in the study," Heldens says. "We may say, 'You will have 12 visits over three years,' and we'll have a couple of sentences about what those visits entail, although we don't go into details of the visits."

More information is given later in the document. "We make exceptions when they are unusual visits," Heldens says. "If a population that wouldn't otherwise have a CT scan is going to have a CT scan, we'll say, 'You'll have a CT scan and be exposed to radiation.'"

Or, if the study population typically would undergo one MRI or CT scan, but the study calls for three MRIs or CT scans, that is included in the key information, he adds.

• **Select writers.** The COMIRB piggybacks the writing of key information to the IRB staff's normal workflow.

"When a study comes in, one member of the staff is in charge of prescreening, and is required to become familiar with the study," Heldens explains. "That person sticks with the submission from the beginning until it's approved."

This person is a natural fit for writing the key information because the coordinator already knows the study application well, he adds.

New IRB coordinators are not asked to perform this task. Their managers will write it for them, he says. "Teaching people to write key information takes time," Heldens notes. "If they know how to edit and are familiar with the consent form, they can pick sentences off of it."

The writers also need to learn how to summarize. When they have finished the first draft of a key information page, the IRB manager will review it and provide feedback.

"The manager will sit down with them, showing them templates and guidance, and go over that information, giving them real case examples," Heldens says. "They don't practice on fake studies; they practice on real submissions in real time. The managers know how to do this very well, so feedback is and editing are quick."

Feedback Is Necessary

• **Obtain feedback.** Initially, investigators wanted to know why they need that key information page. But over time, they came to accept it, Heldens says.

"There are some study teams that, after they got a few examples, started writing it themselves. There's no problem with that," he says.

The IRB staff found it interesting to try something new that involved using their creativity, he notes.

"I practiced a number of these, and I found it rewarding," Heldens says. "It's an activity we don't always get involved in, and it's different between editing and writing." ■

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Chinese Gene Edit Researcher Receives Three-Year Sentence

By Gary Evans

A rogue scientist who shocked the research community by genetically editing human embryos has been sentenced to three years in prison in China, according to the state-run press.

"Chinese researcher He Jiankui was sentenced to three years in prison and fined 3 million yuan (about $430,000) for illegally carrying out human embryo gene-editing intended for reproduction, in which three genetically edited babies were born," the Xinhua news service reported.[1]

The court in Shenzhen, China, handed down the ruling, which said in part that He Jiankui, who obtained a PhD at Rice University in Houston, was not qualified to work as a physician.

"He has no medical training and no training in running clinical trials — really no qualifications whatsoever to be overseeing a clinical trial, if you want to call it that," says **Kiran Musunuru**, MD, PhD, MPH, a cardiologist and the director of the Genetic and Epigenetic Origins of Disease Program at the University of Pennsylvania.

Gathering what limited information is available, Musunuru has been following the case carefully, expressing outrage at the flagrant breaches of common ethical principles. *(For more information, see the story in the January 2020 issue of* IRB Advisor *at: https://bit.ly/2NuxeY5.)*

"It involved experimentation on unborn babies," he says. "There were problems with informed consent and misrepresenting the benefits and risks. All these are things that a proper IRB would have considered before letting him go forward. He was nailed on misrepresenting himself as a physician."

A former associate professor at Southern University of Science and Technology in Shenzhen, He Jiankui was convicted along with two colleagues from medical institutes in Guangdong Province, the news service reported. They received jail terms of two years and 18 months, respectively, but were given a "two-year reprieve" that was not fully explained in the Xinhua article.

"According to the verdict, the three, not qualified to work as doctors, had knowingly violated the country's regulations and ethical principles to practice gene editing in assisted reproductive medicine," the Chinese news service reported. "[The court] said their acts were 'in the pursuit of personal fame and gain' and have seriously 'disrupted medical order.'"[1]

A Chilling Effect?

There is a diversity of opinion on the verdict, with some seeing the prison time as excessive.

"If this was in the West he probably would have lost his position, been unable to get funding. There would have been professional implications," says **Craig Klugman**, PhD, a bioethicist and member of the IRB at DePaul University in Chicago. "I do have a concern about the fact that he was arrested and imprisoned. I think the best deterrents are ones that effect people's professional lives."

The sentencing could have a chilling effect on researchers who want to push the boundaries while staying within legal and ethical obligations, he adds.

"The response should be proportional," Klugman says. "To me, this seems disproportional. I am afraid that it could dissuade somebody who wants to do something cutting-edge, but fully within the law with full informed consent and within ethical guidelines."

He Jiankui announced at a November 2018 scientific meeting in Hong Kong that he had genetically modified twin embryos. It has since been learned that a third modified baby has been born, Xinhua reported. The researcher used CRISPR-Cas9 to edit the human genome to confer resistance to HIV infection.[1]

The experiment shocked the scientific community, which cited widespread agreement that there were too many unknowns to proceed with CRISPR in human subjects. Given the gravity of the situation and possible downstream adverse effects on the gene-edited children, Musunuru says the punishment fits the crime.

"I tend to feel that having jail time as part of the sentence along with the financial penalty is appropriate," he says. "He had many ethical breaches. Whether he, strictly speaking, broke Chinese law is a little bit ambiguous, but a Chinese court determined that he did."

Currently in the United States, the FDA is not allowed to consider

any application for clinical trials that involve modification of a germline or modification of human embryos, Musunuru says.

"In the United States, if you did this sort of thing, you would be breaking U.S. law in violating the Food, Drug, and Cosmetic Act," he says. "An individual who commits a felony violation of that act could get a maximum penalty of three years and a fine of $250,000. It is actually not that different to what He Jiankui received as a sentence in China. On an ethical basis, I feel like he got off pretty light, considering all of the things that he did." ■

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Social Media Effective Tool to Recruit Youth for Research Studies

Researchers are turning to social media to recruit participants, with a recent study revealing that Instagram and Snapchat are effective ways to reach youth.[1]

"Given the near-universal use of social media by youth, using these platforms to reach them is quite effective, and can greatly facilitate their participation in research," says **Sheana Bull**, PhD, MPH, one of the study's authors and professor of community and behavioral health at Colorado School of Public Health.

Researchers used social media to recruit youth age 13 to 20 years in Colorado for a study to evaluate familiarity about age restrictions for recreational marijuana. "We wanted to share our experience in using social media to recruit for public health research," Bull says.

Ads were placed on three social media platforms, encouraging the completion of a web-based survey. Over two months, 828 eligible youth completed the survey. "We were surprised at our success in reaching youth through Snapchat," Bull reports. The researchers anticipated the variable success with Facebook and Instagram, since youth are not using these platforms consistently.

Considering the success of the social media approach, Bull sees ethical implications. "It is imperative to have diverse voices represented in health-related research," she says.

Some researchers have a preconceived notion that youth will not talk to adults or engage in research. "When we work to include their perspective by reaching out to them where they are — online — we are better able to adhere to high-quality standards for participant engagement in research," Bull offers.

Benefits and Barriers

Another group of researchers interviewed 44 physicians on their attitudes toward using social media for cancer therapeutic trials.[2] "The motivation of the study was to understand how physicians understand social media use in the service of improved enrollment in clinical trials," says **William Dale,** MD, PhD, one of the study's authors and a clinical professor in the department of supportive care medicine at City of Hope in Duarte, CA.

Dale and colleagues wanted to know how physicians viewed the advantages of recruiting via social media, and also what concerns they expressed. Key findings:

- Physicians recognized the benefits of using social media for clinical trial recruitment;
- Physicians noted multiple barriers. These include more time and administrative burden, and the risk of misinformation.

"These barriers may lead to a lack of access for certain patients as we are increasingly dependent on social media for our information sources," Dale suggests.

Physicians reported a need for institutional-level interventions, such as:

- restructuring of clinical trial offices to include personnel with social media expertise;
- increased evidence-based approaches to social media use;
- more physician training on the use of social media.

Community-based and academic-based physicians made similar observations and expressed similar reservations about social media use. This came as somewhat of a surprise, according to Dale: "We assumed the academic physicians would be more familiar with social media, more likely to endorse it and less likely to see barriers."

Not a Loose Zone

Social media should not be assumed to be a "loose zone" in terms of research methods or participant welfare, says **Katrina A.**

Bramstedt, PhD, secretary general at the Luxembourg Agency for Research Integrity. "Researchers must still adhere to the principles of research ethics and integrity," Bramstedt cautions.

Many social media forums are used by vulnerable populations, such as children, students, and the terminally ill. Sensitive topics are discussed: mental health, sexuality, health status, and financial status. "Researchers should not assume that social media data, even when public, are permitted for their use," Bramstedt adds. Researchers should follow these practices:

• **Review each website's terms and conditions to understand and honor the data restrictions.** Social media platforms need to "sharpen their moral compass" regarding data security and transparency, Bramstedt says. For instance, terms and conditions need to be written in lay language.

"Also, they need to be presented in a manner such that users are encouraged to actually read them, rather than simply check the box to access the site," Bramstedt adds.

• **Access private web spaces only with the express consent of the owner.** Be sure to secure their permission to perform institutional review board (IRB)-approved research, too.

• **Take care to avoid disclosing the identity of social media participants.** "Privacy is a complex topic due to the ease at which social media narratives can be searched and potentially traced to their author," Bramstedt observes.[3]

"Researchers should not hide or fake their identity to lurk in private web spaces and collect data without consent. This is unethical," she says.

There is guidance researchers can consult regarding ethical use of social media for clinical trial recruitment:

• The Association of Internet Researchers offers guidance on ethical research practices (Read more at: http://bit.ly/33pfsLs);

• The British Psychological Society has produced Ethics Guidelines for Internet-Mediated Research (Read more at: http://bit.ly/32nCZLq).

Some academic libraries also have produced general guides. Bramstedt suggests university librarians and ethicists co-teach seminars on social media research. Also, she says ethicists should provide research ethics trainings in hospital and academic settings. "Researchers may find this to be a research landscape that is unfamiliar to them, or they are not fully aware of the hazards," Bramstedt adds.

Same Rules Apply

Researchers who use social media for recruitment must follow the same rules and policies that are required with flyers, handouts, radio, or television, says **Thomas J. George, Jr.**, MD, FACP, associate director for clinical research at University of Florida Health Cancer Center.

This includes the IRB preapproving any information given to potential subjects to ensure it is not misleading, inaccurate, or biased. "Most researchers who use social media to recruit subjects do so through general awareness-raising of the research, the need for the question being asked by the study to be answered, or where more information can be found," George notes.

The safest way to use social media in this regard is to simply share preapproved information about the trial, without making any false claims about the research. "In other words, using social media as a digital venue for distributing the IRB-approved educational or promotional materials will prevent researchers from unintentionally overstepping ethical or regulatory boundaries," George explains. Consider these other clearly unethical practices:

• Providing incorrect or false information to entice potential subjects to contact research staff, or offering enticements, payment, or favor for participation if the IRB did not approve those already;

• Falsifying social media endorsements from patient advocacy, foundation not-for-profit groups, or expert testimonials as a way to make the research appear more acceptable to the lay public;

• Overemphasizing the benefits while minimizing the risks of potential participation in the research.

On the other hand, asking "influential" social media users to share, like, or retweet the post is more of a gray area. "Some of this can be mitigated by referencing the account holder's profile disclaimer that 'retweets or likes do not constitute an endorsement,'" George says. ■

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CME/CE QUESTIONS

1. **A recent study about cancer drug clinical trials showed which groups were consistently underrepresented as participants in the studies?**

   a. People under age 30 and LGBTQ populations
   b. South Asians, Hawaiians, and Native American populations
   c. Black and Hispanic groups
   d. Muslim, Chinese, and Pacific Island groups

2. **The current situation excluding pregnant women from clinical trials can be traced in part to the cancer risk of which synthetic estrogen in the 20th century?**

   a. Phytoestrogen herbs
   b. Thalidomide
   c. Diethylstilbestrol
   d. Sodium barbital

3. **Which did Pamela Payne, D. Bioethics, BSN, MSM, NP, recommend for IRBs regarding including pregnant women in trials?**

   a. Grant temporary board membership to pregnant women.
   b. Review prior trials for evidence of unjustified exclusion of pregnant women.
   c. Seek legal advice on the liability of fetal harm.
   d. Consider additional safety monitoring to ensure regulatory protections are met.

4. **According to John C. Heldens, RAC, CIP, which information should be included the informed consent's key information?**

   a. Study investigator's name, study enrollment incentives, risks, benefits
   b. Study's purpose, procedures, risks, benefits, alternatives
   c. Trial sponsor's contact information, list of study sites, expected beginning and end dates
   d. Preamble, description of the study, IRB's name, number, email