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INSIDE

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Using Prisoners as Research Subjects Raises Ethical Concerns

A counter-trend of participation discouragement

By Gary Evans, Medical Writer

Human research in prison populations traditionally has raised ethical concerns that the incarcerated may be pressured to participate in a clinical trial. Thus, specific protocols and protections are federally required to protect prisoners from coercion into research participation. However, a recent study[1] found a surprising counter-trend: A "significant minority" of research participants reported pressure to not participate in trials, both from fellow prisoners and correctional staff.

"I was very surprised by that," says lead author **Paul P. Christopher**, MD, assistant professor of psychiatry and human behavior at Brown University in Providence, RI. "If you look at the ethics literature to date on concerns about prisoners, it has always been about whether they were going to be pressured to enroll. That's been the historical precedent. This is the first time that I am aware of that anyone has identified dissuasion from enrolling."

> "THIS IS THE FIRST TIME THAT I AM AWARE OF THAT ANYONE HAS IDENTIFIED DISSUASION FROM ENROLLING."

To assess how prisoners make decisions about enrolling in research, Christopher and co-investigators recruited prisoners who previously had participated in clinical trials. A total of 55 prisoners agreed to be interviewed after providing informed consent to participate in the IRB-approved study. They previously had enrolled in clinical trials that included research on addiction, HIV risk behaviors, and depression.

"No participant in our sample

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reported a perception of being coerced into a study," the researchers reported. "On the contrary, most described how they were specifically, and in some cases repeatedly, informed of their freedom to decline enrollment with assurance that doing so would not adversely affect their jail or prison stay. … Nevertheless, a significant minority of participants described factors that pressured against participation. These included perceptions that participation would be publicized, that their responses to some questions would not be kept confidential, and that they might be mistreated or discriminated against by correctional staff — particularly correctional officers and, less frequently, nurses who work in correctional settings."

A Novel Finding

Though the prisoners decided to participate in their respective trials regardless, Christopher found the results puzzling and certainly worthy of further research in a larger study.

"It took a number of different forms, most notably among the correctional staff," he tells *IRB Advisor*. "Correctional officers made it clear they didn't like the study happening. Other inmates dissuaded people from enrolling or staying in a study by mocking them. In some cases, nurses who were employed by the correctional system made it clear that they didn't like the study, either. That's definitely a novel finding, though it seems to be present in a minority of prisoners."

Overall, 17 participants (30.9%) reported having been discouraged from participating in a clinical trial by a family member, friend, loved one, or another prisoner. "When the influence came from another prisoner, it tended to be a negative statement about the study or researchers," the researchers found. "For example, that it wouldn't be helpful, that it wasn't worth the time required, that researchers cannot be trusted, or ascribing negative labels to participants."

In addition, 16 participants (29.1%) reported being discouraged from enrolling because they had overheard correctional officers making negative comments about the study. Eleven of these participants came from substance abuse trials.

"Six participants (10.9%) expressed concern that certain correctional medical staff members would treat them less favorably than other inmates if they enrolled because of a perception that these staff members were biased against the research study," Christopher and colleagues reported. "As one participant said, 'The nurses [will] tell you straight up they don't like [the study]. They don't like having to deal with it. This [is] actually work for them — they don't think they should give [the study medication] to anybody in jail at all.'"

Pendulum Shift

Again, these were prisoners who were discouraged from enrolling, but ultimately participated in the study. Given these findings, a larger study should look specifically at prisoners who choose not to enroll in research, Christopher says. "Because if they chose not to enroll because of these dissuasive influences, that is a big concern," he says. "The pendulum may be shifting away from coercion to enroll — from a time when prison researchers and authorities were working together in sponsoring research enterprises. [Now]

researchers are very separate and come into the prison to conduct their research. So much so that the prison officials and correctional staff may view researchers as a kind of burden. They may be motivated to not cooperate with researchers or actually put things in place that thwart the research. That may actually keep people from enrolling in clinical research that has the opportunity to help people."

In a sense, clinical research and incarceration are grounded in different social constructs. While clinical research seeks to identify ways to improve prisoners' health and well-being, traditionally prison is a place of punishment and remediation.

"It is, therefore, not surprising that some correctional staff members would view research unfavorably, especially if it seems to provide special treatment to prisoner participants or creates additional administrative burdens," the authors reported. "Nevertheless, given the degree to which prisoners identify the available correctional healthcare as inadequate and seek to access treatment through enrollment in clinical research, any form of dissuasion from prison staff or prison culture is problematic."

Concerns about privacy, which have been identified in previous studies, also were cited as a potential barrier to enrollment. Overall, 16 participants (29%) described how their study participation while incarcerated might breach their privacy.

"Everything that happens in prison is everybody's business, so if you're enrolling in a study that requires you to be HIV positive, there are concerns that your HIV status will then be made public," Christopher says. "Or if you are enrolled in a certain type of study of drug abuse [and are taking a maintenance medication for that] you're called over the loudspeaker to come get your dose. Those kinds of things wouldn't occur in a community setting. They seem to be unique to prisoners."

There are measures that can be taken to protect privacy and mitigate these concerns to some degree, "but there is nothing you can do about gossip in the prison system," he says. "It's an institutional phenomenon."

"IT'S A POSITIVE FINDING THAT THEY PERCEIVE THAT ONE ASPECT OF INFORMED CONSENT WAS PRESENT — NOT THAT THEY WERE INFORMED, BUT THAT THEIR CONSENT WAS GIVEN VOLUNTARILY."

A positive finding is that no participant reported being directly coerced into joining or staying in the research study. In fact, 43 (78.2%) specifically indicated an absence of coercive influences. *IRB Advisor* asked Christopher if this finding can be read as a kind of surrogate measure of informed consent.

"It's a positive finding that they perceive that one aspect of informed consent was present — not that they were informed, but that their consent was given voluntarily," he says. "We didn't assess their decisional capacity. We didn't assess whether they had a full understanding of all the details of the study. That would require a whole other set of measures."

Protective Measures

Given the very nature of incarceration, prisoners who enroll in federally funded studies have protections in place that go beyond those that apply to traditional human subjects research. According to Christopher and colleagues, these include the following permitted categories for proposed prison research. The last two on this list require approval from the Department of Health and Human Services (HHS) Office for Human Research Protections. The four categories are:

- minimal-risk studies on possible causes, effects, and processes of incarceration and of criminal behavior;
- minimal-risk studies of prisons as institutional structures or of prisoners as incarcerated persons;
- research on conditions particularly affecting prisoners as a class;
- research on practices that are intended and deemed likely to improve the health or well-being of participants.

"I think for IRBs the question is, what is the clinical research offering in terms of immediate benefit to the participant?" Christopher says. "If there aren't obvious immediate benefits to the participants, are there potential benefits to prisoners as a class if the outcome of the study is implemented on a policy level? If you look at the federal guidelines as they are currently laid out, it is very clear that any minimal-risk study can proceed on sort of the institution of

incarceration — studying prisoners because they are prisoners, the phenomenon of being incarcerated. The above-minimal-risk studies have to do with health conditions that seem to predominately affect prisoners, or research that is looking at policies and practices to improve the well-being of prisoners. Even if it is just slightly above minimal risk, it still has to go to the federal level to be approved to be conducted."

In addition, the IRB reviewing a study must include a prisoner or prisoner representative in deliberations. A majority of board members cannot be affiliated with the prison in which the proposed research would be conducted. The IRB providing review and oversight also must weigh whether the study risks would be acceptable to non-prisoners, the authors emphasized.

"That is an important consideration," he says. "If the answer to that is 'no,' then that is something that an IRB may want to decline to approve."

Coercion vs. Exploitation

In the study, 46 (83.6%) of the prisoners said they enrolled because they have few alternatives available to them while incarcerated, or because of dissatisfaction with the treatments offered by the prison.

"If the available care is, indeed, so poor, some prisoners may feel that in order to receive care, they have no other choice but to participate in research," the authors noted. "While it may be tempting to equate this sort of dilemma — choosing between entering a study and forgoing adequate care — to a kind of coercion, we believe that in the context of research, it is more accurate and constructive to frame the ethical issues in terms of the potential for exploitation and the need to ensure that studies have an appropriate risk-benefit ratio."

Christopher and colleagues chose to frame the ethical dilemma along the lines of exploitation because it more accurately captures what is happening in the interactive relationship between a researcher and a research participant, he says.

"Remember, research always proposes to exploit its subjects in some regard," he says. "We are asking you to assume a certain level of risk to test the efficacy of an intervention. That is, by definition, exploitation.

> "YOU HAVE TO HAVE A CONVERSATION ABOUT WHETHER PEOPLE'S BASIC NEEDS ARE BEING MET BEFORE YOU CAN HAVE A CONVERSATION ABOUT COERCION."

That question is whether the exploitation rises to the level of unfair in terms of its distribution of benefit and the amount of risk that it poses. That is where we shifted our discussion to really look at what are the benefits that are being purposed."

Balancing the risks and benefits addresses the exploitation to some degree, but coercion may still be present in prisoner research, says **Keramet Reiter**, PhD, assistant professor of criminology, law, and society at the University of California, Irvine.

In an editorial reflecting a dissenting opinion to the Christopher study, Reiter disagreed with the authors' conclusions about both the absence of coercion for prisoner clinical research participants and the merits of applying risk-benefit models to govern prisoner research participation.

"First, the authors conclude that the prisoners were not coerced into participating in earlier clinical research protocols, even though nearly one-quarter of participants felt 'desperate, very scared, or extremely worried about the potential consequences of their illnesses' if untreated," she wrote. "They argue that, when prisoners are presented with the difficult choice between entering a study and forgoing adequate care, this is not coercion as long as no one has threatened them with being worse off if they do not consent to participate."

This position fails to account for the severity of conditions and the lack of healthcare in U.S. prisons, she argues.

"I think they are arguing for this kind of shift in thinking — instead of thinking about coercion, think about exploitation and the great [research] benefits prisoners could have," she tells *IRB Advisor*. "I am basically saying we have to step back before we can engage in that kind of balancing and ask, 'Are people's basic needs being met?' If they are not, then there is a potential for coercion, no matter what they want or how much they could be helped by a trial. If they don't have basics [necessities] and are worried about their actual ability to live, to have clothes and hygiene products, then you can't even begin to have a conversation about coercion. You have to have a conversation about whether people's basic needs

are being met before you can have a conversation about coercion. I think that is the why the regulations exist in the first place."

Agree to Disagree

The two academics may have to agree to disagree on this one, as Christopher questions Reiter's link between basic needs and coercion.

"If this is true that [prisoners] are not actually getting [basic needs met], which they have a constitutional right to, then as a society we are going to have to figure out if and how we are going to address that problem," Christopher says. "That is a separate issue from research ethics. It certainly has implications for research ethics, but I don't think it means — as Reiter points out — that clinical research should not proceed in some regard solely because prisoners perceive that the healthcare that they are getting is inadequate. She frames the issue as one of coercion if their basic needs aren't getting met, and their only perceived option to get those needs met is to enroll in research. That [to her] constitutes coercion. She can hold that view, but I think it conflicts with what the majority of bioethicists would conceptualize coercion as being, which is that it entails some sort of threat to be made worse off if one declines [to participate in research]."

Reiter cites her own 2009 study[3] and some investigative journalism reports that raise concerns that, even under the protections and parameters that are required for incarcerated populations, there are some abuses going on in prison research.

"[Christopher and colleagues] were incredibly thoughtful and ethical in their work, but when you look at the range of research that is happening in prisons, it turns out to really be hard to govern it," she says. "I worry about the principles they suggest [being misused by] people who have less worthy motivations. That is the history of this. In spite of pretty rigid regulations, there have been cases like the one in Texas where prisoners were basically sentenced to treatment with an experimental drug treatment. They were functionally participating in a clinical trial."[4]

In her aforementioned study, Reiter reviewed violation letters send out by the HHS on prison research.

"There were a surprising number happening every year, suggesting that even given the fairly rigid protections we have now, some people are conducting research that violates the ethical norms and is both exploitive and coercive," she says.

A lot of oversight and protection is being provided by university IRBs for this kind of research, but there also are prison studies that may involve "IRB shopping" and other unscrupulous methods, Reiter says.

"I think it happens more than people think," she says. "The other real challenge is trials that are happening outside of a university context, because private drug companies can run trials in private punishment facilities. And that is a truly scary thing. That is outside of the federal regulations we assume exist. We set up principles, but then there are all these loopholes even within the principles we have. If there is any kind of federal funding involved there would need to be IRB approval, but it could be a fairly privatized process. Sometimes private drug companies set up their own IRBs."

The studies from which the 55 subjects were recruited all were studies that were carefully vetted by academic IRBs, by the prison system IRB, and by OHRP, Christopher says.

"I think Reiter's probably correct in raising the concern that there are correctional systems somewhere in the United States that are probably not following those guidelines," he says. "Perhaps there are some that are even receiving federal funds and are undergoing reviews by IRBs and academic centers, but those aren't the ones that we studied. My experience has been that IRBs go the extra mile in protecting prisoners from both coercion and exploitation."

Reiter sees a glass half full, cautioning against human research continuing under current prison conditions.

"I could imagine a world in which a clinical trial in prison would make a fair amount of sense, but I have a lot of concerns given the prison conditions we have today," she says. "In an ideal scenario certainly, particularly clinical trials that are geared toward the problems prisoners are experiencing. Even then I think I have the same concerns about the sort of baseline conditions and problems in our prisons." ■

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Future World Without Paper Consent Could Be Here Sooner Than Imagined

Remember when the IRB submission process was entirely on paper? In 2027, someone might ask the same thing of informed consent: "Remember informed consent paper documents?"

Electronic consent has great potential for growth, says **David Forster**, chief compliance officer with WIRB-Copernicus Group in Princeton, NJ.

"But the process needs to be more administratively efficient and affordable," Forster says.

Forster says WIRB-Copernicus sees some e-consent forms from sponsors, but the percentage still is quite low.

"Ten to 15 years ago, everyone was converting from paper forms to EDC [electronic data capture], and now every study is EDC instead of paper. We will see the same change with e-consent," says **Anthony Costello**, vice president of mobile health with Medidata Solutions in Davis, CA. Costello was the founder of Mytrus, which developed Enroll, an e-consent process. Mytrus was purchased by Medidata in April 2017.

"Over the next five years or so, I believe that the paper-to-electronic-consent movement will mirror what we saw with paper to the electronic data capture movement," Costello adds.

"My prediction is we'll see a much more rapid adoption of e-consent in the next year or two," says **Kyle Maeda**, vice president of information technology at Kinetiq, a division of Quorum IRB in Seattle.

Others say that within seven years, most clinical trials will use an electronic consent process. These won't be costly e-consent and patient educational tools, but a more streamlined version that works better for standard pharmaceutical and device trials.

The nonprofit Sage Bionetworks of Seattle has used e-consent on some research projects. The organization created its e-consent using Apple's ResearchKit software and also consulted with other first adopters of e-consent, says **Christine Suver,** PhD, director of research governance for Sage Bionetworks. ResearchKit is an open source framework for creating a medical research tool. *(For more information on ResearchKit, see the story "Smartphone Apps Are a New Frontier for Minimal Risk Studies" in the May 2015 issue of* IRB Advisor.*)*

"Our studies were different from traditional clinical trial studies," Suver notes. "They were designed to be self-managed and self-implemented."

The e-consent took about six months to create, from the first concept to design, to coding, and to working with the IRB, Suver says.

Participants can download an app and view information about the research study. If desired, the participant then could view the e-consent and sign it electronically from their cellphone. Participants also would do the study on their own.

"Those studies were designed to be implemented, self-paced, and have participants be able to do it on their own outside of a clinical study site," Suver explains. "Because the study was self-administered, we needed to design a consent process that was similarly self-paced and administered within the application."

E-consent has a few drawbacks before wide adoption is a reality.

For instance, the systems often are difficult to present to the IRB in the same format the subject sees, and the electronic signatures need to be compliant with 21 CFR Part 11, Forster says.

"And amendments, likewise, can be difficult to process. Also, paper is cheap in comparison to electronic platforms, and that can be an issue," Forster says.

International regulations also can pose an obstacle to e-consent because it is challenging for research sites and IRBs to know of a nation's related data privacy laws, data storage, electronic signature process, and other rules that differ from country to country, Costello says.

One of the benefits of an electronic consent process is that it can prevent the human errors and omissions that slow down the research process.

"It's very easy to miss signature lines, datelines, and an electronic consent would eliminate those deviations," says **Raymond Nomizu**, JD, co-founder of Clinical Research IO of Cambridge, MA.

IRBs and research sites should seriously consider moving to paperless processes, including e-consent, Nomizu says.

"The real reason why people should go electronic is because of the impossibility of managing current protocols on paper forms," he says. "It's really hard to manage that complexity, and trials are getting more complex every year."

E-consent can do things paper consent documents cannot, says **Mitchell Parrish**, JD, RAC, CIP, vice president of legal and regulatory affairs for Kinetiq.

"With e-consent, you actually have the ability to reduce compliance risks," Parrish says. "You have the smart form approach, so you will know the form

is not complete until it's completely filled out."

The e-consent process locks in the correct version of the informed consent, so everyone signs the correct form. It has built-in mechanisms that ensure compliance from the site's perspective, he adds.

"E-consent is not just meant for remote, online consenting," Parrish says. "You see it as the standard for how you consent. It's a best practice."

Another time-saver is in how trial amendments and repeat consenting are handled. When a study amendment results in a revised informed consent for research participants to sign, it can cause delays. With an e-consent process, this can be handled more efficiently.

"If the IRB had approved remote consent, then study participants can review and approve the revised informed consent remotely," says **Tom Favillo**, president and chief operating officer of Quorum IRB.

E-consent is something the human research protection industry has been trying to push for the last four years, Favillo says.

There is interest in paperless consenting processes, but there have not been great tools available on the market. And the tools that were available often required investment in hardware and software, he says.

"Most tools have come from an educational perspective, versus a consent perspective," Favillo says. "When they came to market, they did bring positive elements of engagement and retention."

But the drawback was that the time spent on designing these electronic consent tools added months to the research process, he says. "The benefit of paperless consent did not offset that expense."

That was then, and this is now: E-consent tools can be adapted to most studies. If research sites wish to add explanatory videos or other visual or auditory aides, they can.

"But it's not something you have to have if you don't need it for your study," Favillo says.

Another benefit of an e-consent platform is it gives sites real-time metrics.

"You can see who has consented," Parrish says. "You can see how the site is doing on enrollment, and which version of the informed consent was used in enrollment."

Sponsors and clinical research organizations have real-time access, and it can reduce costs, he adds.

"People can access the electronic consent from any internet-enabled device," he says.

As these tools become better known, there will be more like them. Soon — perhaps within 18 months — there will be quick adoption of e-consent, Favillo predicts.

"The biggest benefits of e-consent are about getting this information in a place and platform that participants can interact with when they need to," Favillo says. "It secures data, allowing data to be used across multiple studies."

Another e-consent benefit is the prospect of participant engagement.

"With electronic consent, you're giving people an opportunity to interact with the document in a way they're more familiar with — online," Parrish says. "You can interact with the research staff, principal investigator, or clinical research associate."

With paper consent, participants might take it home, jot down questions and notes, and then return to the research site to learn more. With e-consent, they can type in questions and send them automatically to the site. Then the research site can respond through the e-consent platform with questions or answers.

"It's an easier way to have participants engage with research sites and to make sure all questions are answered," Parrish says.

Sage Bionetworks was motivated to design an e-consent so that it would increase engagement and allow research participants to be more autonomous in their decision-making, Suver says.

E-consent makes it possible to add multimedia functions, including visual tools, graphics, and other technology.

"We inform participants in a multimedia approach with words, video, icons," Suver explains. "Then we guide them through what the study is about and what the risks and benefits are."

All of the traditional informed consent topics are addressed in an e-consent form. The difference is the information provided electronically is more accessible, and it can be easier for some types of learners to understand, she adds.

The e-consent app developed by Sage Bionetworks is available on the Apple iTunes store for download. "We welcome any feedback on improving the process," Suver says. "We are continuing to really try to evolve this e-consent process to make it more engaging."

There are some challenges to switching to an electronic consent process, including ensuring cybersafety. *(See story on e-consent obstacles and challenges, page 68.)*

But the benefits outweigh the risks, according to Parrish, Favillo, and others.

E-consent is very efficient and will become the industry standard, Parrish predicts.

"It will maximize clinical trials. There are industry work groups working on it, and people will put out new products," Parrish adds. "All signs are pointing toward wide adoption, and that's why these are exciting times." ■

Electronic Consent Has a Few Obstacles and Drawbacks

Chief obstacle: Fear of change

All but a small percentage of research sites use paper informed consent documents. Although daily activities like shopping, listening to music, watching videos, and interacting in social groups are frequently done in electronic platforms these days, informed consent is not yet fully there.

This is why adoption of electronic consent will not occur overnight.

"There's a fear of change, a fear of the unknown," says **Raymond Nomizu**, JD, co-founder of Clinical Research IO in Cambridge, MA.

"A lot of sites are on tight budgets and do not have the funds for additional technology," Nomizu says. "Like with any software implementation or change of behavior, there are a lot of questions."

Security is another possible issue for IRBs. Healthcare organizations have been big targets for cybercriminals in recent years, exposing major security and HIPAA lapses. But research institutions and IRBs can take steps to ensure security.

For example, Quorum IRB uses a third-party firm to audit its security and ensure there are no weak spots, says **Kyle Maeda**, vice president of information technology at Kinetiq, a division of Quorum IRB in Seattle.

"They do a black-box penetration test to attack our network to see if they can get into it," he says.

Third-party audits and penetration tests can validate your organization's cybersecurity measures. The theory is that if there is vulnerability, the test will find it. Most cybercriminals will go after the low-hanging fruit, skipping organizations that have adequate security.

"If you have an alarm system and your neighbor doesn't, which house would a criminal choose?" Maeda says.

> "THE BEST YOU CAN DO RIGHT NOW TO KNOW THAT THE TOOL IS COMPLIANT WITH PART 11 IS TO WORK WITH A VENDOR THAT USES A LARGE AUDITING FIRM AND HAS SOMETHING IN WRITING ABOUT THE AUDIT."

IRBs and research organizations can require e-consent tools to be compliant with FDA regulation 21 CFR part 11, says **Mitchell Parrish**, JD, RAC, CIP, vice president of legal and regulatory affairs for Kinetiq.

The FDA published its final guidance on the use of electronic consent on Dec. 15, 2016. The guidance discusses how to present information in an electronic informed consent, where to conduct the consent process, how to answer subjects' questions, how to use electronic signatures, and other issues. The FDA guidance is available at: http://bit.ly/2pckWaX.

The guidance makes vendors responsible for regulatory compliance, but research organizations should ensure the vendor can verify compliance, Parrish says.

When research sites want to use an e-consent tool, their study submission to the IRB will include one. The IRB can ask for written verification that the tool is secure and compliant with part 11.

"The best you can do right now to know that the tool is compliant with part 11 is to work with a vendor that uses a large auditing firm and has something in writing about the audit," Parrish says. "There is nothing official available right now; there is no governmental certification. So, it's up to vendors to put themselves through the test."

Some might question whether an electronic signature can be forged. The answer is that it's as accurate as a handwritten signature, Maeda says.

"The way electronic signatures work is you need multiple pieces of information to authenticate that it's you," he explains. "We don't need a wet signature; i.e., pen and paper."

What is needed is a one-time login. Then the participant will validate who he or she is.

"When we set up our accounts, typically, you have user email and date of birth to validate that whoever logs into the system can electronically sign with the appropriate identifying information," Maeda says.

An organization's IT department then provides back-end validation. "We make sure we don't have suspicious logins coming from unauthorized sources," Maeda explains.

"For example, if someone tries to authenticate with an email and date of birth that do not match, we flag that in the system and don't allow it."

IT experts also check for logins from multiple locations. If someone were to attempt to login from Seattle one day and from New York the next day, IT staff would see that and be able to track it, he says.

"We can see the IP addresses someone is coming from," Maeda says. "It's fairly straightforward auditing and logging of events and collaborating that information."

Other security concerns, such as placing participants' names on the electronic cloud, are misplaced, Maeda says.

"There is a misconception that when data is on my server, it's more secure, and that's not always the case," he says. "There are frameworks that ensure that any kind of application, whether on your premise or in the cloud, is secure."

When IRBs first are presented with an e-consent process, one of the challenges is ensuring people understand what they're reading and what the study is about, says **Christine Suver**, PhD, director of research governance for Sage Bionetworks.

"The first challenge is that people are used to software upgrade agreements that are really long, and they don't read them," she explains. "But in research, we have to have a completely different approach and teach people that participating in a health research project is different than a software update."

Sage Bionetworks installed a small quiz with a set of questions at the end of the consent topic presentation. Research participants complete the quiz to ensure they have read and understood the information.

One of the biggest barriers to electronic consent involves the lack of integration between systems, Maeda says.

"This is a big deal right now at the site level," he says. "If you have a clinical trial management system, it gets confusing about how to manage all those different logins and systems."

This problem will resolve itself when industry and research groups press for standards or when research organizations and health systems work toward more seamless data integration, he says.

More research organizations will adopt e-consent as they see the benefits in efficiency and regulatory compliance, but especially in study participant engagement, Suver predicts.

"It's really helpful to use this new technology," she says. "It gets people the information they need." ■

Self-certification Tool Formalizes Process to Decide Between QI and Research

Submissions dropped dramatically

IRB officials at the University of Wisconsin-Madison realized seven years ago that the IRB was receiving too many requests for review of quality improvement (QI) or other projects that did not meet the Common Rule's definition of human subjects research.

"Because of the volume of these requests, we knew we needed a formal way to make these determinations, and there weren't any other groups at the university that had the expertise," says **Gretchen Anding**, MA, assistant director for the health sciences IRB at the school of medicine and public health at University of Wisconsin-Madison.

"It fell to the IRB to make determinations about whether something needed oversight or not," she adds. "As the requests grew, we started to wonder whether we were using resources in the best way."

The IRB was burning through staff resources. Handling these determinations required a full-time staff reviewer.

"We felt we were using resources to cover people in the eventuality that they might publish or present at some point in the future, even though it wasn't part of their current plan," Anding says. "It seemed like we could be devoting our resources to other things."

Many of the determinations were straightforward. Those determinations seemed to be a waste of IRB resources, she notes.

"We were not using the project person's time well, either. They were

not familiar with our electronic system and had never submitted before," Anding says. "So these kinds of factors led us to think that maybe there's another way we could do this."

The solution was to create a tool that would weed out the straightforward quality improvement projects and program evaluation initiatives from research.

Starting in 2012 and piloting the tool in 2013, the IRB provided submitters with a self-certification document. *(See sample questions from the self-certification tool, below.)*

Four years later, the IRB switched to a different electronic platform and was able to track some basic information about who's using the tool and where they get information in completing the certification.

Use of the tool led to a stunning drop in formal IRB submissions. In the first year, the number of submissions dropped 30%. In the second year, it dropped another 30%.

"The tool has significantly reduced the formal submissions coming to our office," Anding says. "It's enabled us to use staff reviewer time for exemptions and to devote additional staff time to expedited reviews."

The following is how the IRB created and initiated the tool:

• **Create a guidance chart.** "For a long time, we had been talking about the characteristics of research and quality improvement," Anding says.

A chart that compared the characteristics of research with QI projects was on the website for guidance purposes.

"We took that chart and developed it into questions in the decision tool," Anding says. "And that's what we piloted and released in 2013."

• **Start a process for questioning project leaders.** "We created a process in our office for asking specific questions of project leaders, to see how they were doing," Anding says.

"I took what we had been using orally to help people through this decision-making process and turned it into a structured decision tree," she says.

Anding sent it out for review and feedback, then revised the questions.

"We also sent it to our legal counsel and had multiple conversations to make sure people were comfortable with the idea of taking decision-making out of the IRB's hands and putting it into the tool," she explains.

"After discussions and recognition of how many requests were coming in, our legal counsel and others felt the tool was worth pursuing because it seemed like an appropriate use of resources to switch this process and put it in the hands of people conducting research," Anding says. "It also provided an indication of our trust in our researchers and project leaders on campus."

• **Assess its use.** Most people are able to use the tool appropriately. Those who have questions or who have a complicated project can come to the IRB office for assistance, she notes.

Questions From UW Madison's QI Program Evaluation Tool

The University of Wisconsin-Madison IRB developed an online quality improvement/program evaluation self-certification tool that helps project leaders determine whether their projects qualify as research.

The following are some questions and items on the tool:

- List the project title.
- Write a brief description of project/goals.
- Will the project involve testing an experimental drug, device (including medical software or assays), or biologic?
- Has the project received funding (e.g. federal, industry) to be conducted as a human subjects research study?
- Is this a multisite project (e.g. there is a coordinating or lead center, more than one site participating, and/or a study-wide protocol)?
- Is this a systematic investigation designed with the intent to contribute to generalizable knowledge (e.g. testing a hypothesis, randomization of subjects, comparison of case vs. control, observational research, comparative effectiveness research, or comparable criteria in alternative research paradigms)?
- Will the results of the project be published, presented, or disseminated outside of the institution conducting it?

To view the self-certification tool, visit: http://bit.ly/2p5HQOF. ■

"We did an IRB analysis and felt there were a lot of benefits and low risk, based on what we had seen from the pilot and the submissions coming to our office," Anding says.

So far, the tool has received uniformly positive feedback. Many people have used it for quality improvement projects, she says.

"We've been told it is very easy to use and understandable," Anding says. "We have comprehensive guidance for the tool and, so far, it's been positively received."

There were a few times when people misinterpreted the questions, saying they had QI projects that actually were research projects, she says.

"They didn't get very far because another office stopped them and sent them back to us to get on the right process," Anding says.

"When those situations happen, we take a look the tool's questions to see at which point the person got confused or misinterpreted the questions," she explains. "It's a good quality check for us, too. It allows us to make improvements to the tool." ■

Study: Research Misconduct Rarely Reported By Authors of Systematic Reviews

Research misconduct — not publishing completed research, duplicate publications, or selective reporting of outcomes — sometimes is identified by authors of systematic reviews, but is rarely reported, found a recent study.[1]

Researchers analyzed 118 systematic reviews published in 2013. Some key findings include the following:

- Unpublished trials were searched in 66% of reviews.
- Authors of original studies were contacted in 62% of reviews.
- Duplicate publications were searched in 69% of reviews.
- Only five reviews looked at conflicts of interest of study authors. None of them analyzed the effect.
- Seven reviews suspected misconduct, but only two reported it explicitly.

Guidance on when, and how, to report suspected misconduct is needed, the researchers argue.

"Depending on the nature of the misconduct, when the scientific record goes uncorrected, people may rely on invalid 'evidence' to support practice, policy, or their approach to a problem," says **Karen Christianson**, RN, BSN, CCRP, associate vice president at HRP Consulting Group in Lake Success, NY.

This is particularly troubling in healthcare, says Christianson. This is because physicians and other providers may base their approach to treatment on false evidence. In turn, this may result in unanticipated adverse effects, outcomes, or other negative consequences. "Now imagine the impact of this over time, across hundreds or thousands of lives," says Christianson.

Christianson believes there is an ethical obligation to report suspected misconduct — if not to the organization who employs the scientist, then to the journal which published the work in question. "Most scientific organizations and respected journals have established policies and processes to ensure that such concerns are evaluated and, if warranted, investigated," she notes.

Most have established mechanisms for anonymous or confidential reporting, and non-retaliation policies. If misconduct did occur, the work in question is likely to be retracted. "This then sets the path for other scientists to perform research which may validate or refute the prior findings, correcting the scientific record," says Christianson. ■

REFERENCE

1. Elia N, von Elm E, Chatagner A, et al. How do authors of systematic reviews deal with research malpractice and misconduct in original studies? A cross-sectional analysis of systematic reviews and survey of their authors. *BMJ Open* 2016; 6(3):e010442.

COMING IN FUTURE MONTHS

- Organization devises community research training program
- New and improved IRB consent process outlined
- Disaster planning should be on every IRB's priority list
- How to divide up local IRB review and IRB of record review

IRB ADVISOR

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. **Finding that some prisoners who ultimately enrolled in clinical trials reported being discouraged from enrolling, Paul Christopher, MD, said a larger study should be done specifically focusing on:**

   a. correctional officers.
   b. inmates' attitudes toward research.
   c. prisoners who choose not to enroll in research.
   d. All of the above

2. **Keramet Reiter, PhD, argued that the research issue of coercion cannot really be evaluated and discussed if prisoners do not have their basic needs met under current conditions.**

   a. True
   b. False

3. **The FDA published its final guidance on the use of electronic consent on Dec. 15, 2016. Which of the following is covered in the guidance?**

   a. It covers how to establish a cybersecurity audit to keep e-consent secure.
   b. It covers how to present information in an electronic informed consent, where to conduct the consent process, and how to use electronic signatures.
   c. It discusses which vendors would be acceptable for obtaining an e-consent app.
   d. All of the above

4. **Which of the following is not a benefit of moving from paper consent to electronic consent?**

   a. E-consent ensures greater regulatory compliance.
   b. E-consent provides research participants with greater options in how they might learn about the study.
   c. E-consent documents are easier to create.
   d. E-consent makes it easier to monitor the progress of sites in obtaining informed consent.

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.