

CCPH/Bioethics Center Educational Conference Call Series on IRBs and Ethical Issues in Research: Call 1

“What is an Institutional Review Board (IRB) and What Purpose does it Serve?”

February 14, 2007

Speakers:

- **Shirley Hicks**, Director, Division of Education and Development, Office for Human Research Protections (OHRP), U.S. Department of Health and Human Services (DHHS), Rockville, Maryland
- **Bill Freeman**, Director of Tribal Community Health Programs & Human Protections Administrator, Northwest Indian College, Bellingham, Washington

Operator: Welcome. Thank you for your patience. Welcome to today’s Community-Campus Partnerships for Health IRB conference call hosted by Miss Wong, entitled “What is an Institutional Review Board and What Purpose Does it Serve?” This is call number one in a series of calls regarding institutional review boards. A question and answer session will follow the presentation and instructions for asking questions will be given at that time. During the presentation if you experience any technical difficulties please press *0 on your touch-tone phone to speak privately to an operator. Thank you for your attention, I would now like to turn the conference over to your host, Miss Wong.

Kristine Wong: Good afternoon everybody. My name is Kristine Wong, Program Director at Community-Campus Partnerships for Health, and I’d like to welcome all of you to the first call of the educational conference call series on institutional review boards and ethical issues in research titled, “What is an Institutional Review Board and What Purpose Does it Serve?” This call series is being cosponsored by Community-Campus Partnerships for Health and the Tuskegee University National Center for Bioethics and Research and Healthcare, also known as the Bioethics Center. Before I go any further please make sure that you have in front of you the three PowerPoint presentations and the resource sheet sent out in advance of the call. These are titled as follows: 1) Introduction slides, 2) History of IRB’s Hick Slides, and 3) Case Story: Romero Freeman Slides. These slides have been developed as a visual aide for you to follow during each speaker’s presentation. For some reason if you did not receive the slides they can be accessed on the CCPH web site in the near future.

Founded in 1996, Community-Campus Partnerships for Health, also known as CCPH, is a nonprofit organization that promotes health through partnerships between communities and higher educational institutions. Our focus includes service learning, community-based participatory research, and broad based partnerships. We are a growing network of over 1,300 communities and campuses across North America and increasingly the world, tied together by a commitment to social justice and our passion for the power of partnerships to transform communities and academe. The call series is intended to increase understanding of the roles of IRBs and other mechanisms for assuring that human subjects research is ethical and appropriate, both at individual and community levels. The aim of the series is to provide a comprehensive understanding of the options and the tools necessary for communities to determine the approach that is best for them.

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The series will also inform the development of future initiatives undertaken by CCPH and the Bioethics Centers on IRB's and ethical issues in community-campus partnerships. Over the course of the six calls in a series, we will start with the basics of human subjects' protections and provide information about community member involvement on IRBs, then hear perspectives from non-affiliated IRB members and talk about their importance in the review process. We'll then learn from an array of community members and academics regarding why they decided to create further protections for communities through the formation of community advisory boards and independent community IRBs. In addition, we will explore the successes and challenges of CBPR partnerships in getting their proposals through the IRB review process. Lastly, we will conclude the series with a session that presents recent research on IRBs and discuss the implications of this research for future policy and practice. Before we begin, I'd like to remind all of you that this conference call is being recorded, including the question and answer period. A digital audio file of the call will be posted on the CCPH web site at www.ccpb.info, so that anyone can freely access the information covered on these calls. If you ask a question during the Q&A period, please remember that you are consenting to having your question be recorded. We are also planning to use the recordings to develop written products from the call series, such as proceedings. No identifying information about audience members will be included in these written products. Please remember that if you get disconnected from the call, just dial back into the number 1-800-791-2345, access code 51170. Now I'd like to introduce you to today's moderator, Dr. Vanessa Northington Gamble. Dr. Northington Gamble is the Director of the Tuskegee University National Center for Bioethics in Research and Healthcare. At Tuskegee, Dr. Northington Gamble is also a professor of bioethics in the College of Veterinary Medicine, Nursing and Allied Health. A physician and medical historian, she is an internationally recognized expert on the history of race and racism in American medicine, racial and ethnic disparity in health and health care, cultural competence, diversity and bioethics. And now, I'd like to turn it over to Dr. Northington Gamble, who will tell us about the focus of today's call and introduce us to today's speakers.

Vanessa Northington Gamble: Thank you, Kristine. Before I get into talking about today's presentation, I'd like to talk briefly about this partnership because I think that this call series is the first of a series of activities that the Tuskegee University National Center for Bioethics will be doing with CCPH. And I think this is a wonderful partnership because I think that we have two organizations who have a shared goal of meaningfully involving communities and decisions about every aspect of research. And also I'd like to say a few words about the Tuskegee University Bioethics Center. The Bioethics Center was founded in 1999 and in large part because of the presidential apology for the United States Public Health Service Syphilis Study and this apology took place in 1997. The Bioethics Center promotes racial and ethnic diversity in the field of bioethics and in public debates about bioethical issues. The mission of the Bioethics Center is to promote equity and justice and health in healthcare. It is the only Bioethics Center at a historically black college and university and it was the first Bioethics Center that has looked at issues of race and bioethics. And with that I'd like to tell you something about today's conference call. Many times we talk about the legacy of the United States Public

Health Service Syphilis Study at Tuskegee. And one of the legacies that I think we need to talk about and what we will be doing today is how the public revelations of the Syphilis Study led to strengthening of the protections of human subjects and research. And so today's topic is what is an institutional review board and what purpose does it serve. We have two presenters, the first is Shirley Hicks of the Office for Human Subjects Research, who will discuss some of the unethical research projects that strongly influenced the development of health and human services regulations to protect the right and welfare of human research subjects. She will also provide a brief review and a history, and being a historian I'm really glad that she's going to be doing this, of how OHRP continues to strengthen HHS, Health and Human Services, supported human subject research and share some resources for the listeners of this call. We also have Bill Freeman. And Bill Freeman we're very lucky to have, who he agreed to do this on very short notice and we thank you Bill for doing this. And Bill will talk about some of the federal regulations using a case study.

Now let me introduce our two speakers. As I mentioned, Shirley Hicks is the Director of the Division of Education and Development Office for Human Research of Protections of the United States Department of Health and Human Services. And she is snowed-in in Washington like many of us are in Washington today. And as the Director of the Division of Education and Development, Miss Hicks has responsibility for the development and conduct of education and quality improvement activities to enhance the protections of human research subjects. In addition, she frequently serves as a faculty at major conferences, presenting on numerous topics regarding human research protections. She's not new to this field. Prior to joining OHRP, she was a regulatory specialist for the Division of AIDS at the National Institute of Allergy and Infectious Diseases at the National Institutes of Health. And in that capacity, she had the responsibility for helping to ensure regulatory compliance with human subject protections regulation. She's had more than a 30-year nursing career and that's included specialization and clinical research and staff education. Our second speaker today is Bill Freeman and he is Director of Tribal Community Health Program and Human Protections Administrator in Bellingham, Washington at the Northwest Indian College. Bill Freeman. And let me tell you something about the Northwest Indian College. It is a two-year tribal community college that's chartered by the Lummi Nation in Western Washington State. Bill retired from the Indian Health Service in January 2002 after 25 years. And he is a family physician and his first 13 years in the Indian Health Service he was a practicing physician. Bill is also the Human Protections Administrator at the Northwest Indian College and a member of his Institutional Review Board. And in his last 12 years at the Indian Health Service he organized and chaired the Indian Health Service headquarters' IRB. He is a certified IRB professional and he served on the board of PRIM&R, an organization many of you know of which is the Public Responsibility in Medicine and Research. He was on that board for 12 years. And without further ado, I'd like to turn this over to Shirley Hicks.

Shirley Hicks: Good afternoon. Hopefully you have my slide presentation in front of you and for about the next 25 minutes I hope to give you sort of a general overview. And as you will see from the first slide, the outline slide, but I hope to talk just a little bit about

regulated research and then a little bit about the Office for Human Research Protections which is called OHRP. And then to spent the bulk of the time talking about some historical events and the effects that those events had on human subject protections. And this then leads into the reason that we have institutional review boards and we won't go into a great deal of depth about the operations of an IRB, or institutional review board, today but we will start to touch on that subject. Now I realize on the call that we probably have people with varying levels of knowledge and experience so for some of you this might be a bit of a review and for some of you this might be new information. So I'll try to sort of hit the middle of the road, so to speak. So to the next slides, as we start to talk about the U.S. regulations for human subject research. Go to the next slide and you see that when most of us think about research that is regulated we think about really pharmaceutical type research, the research that you hear about as you see the TV ads. That is research that's regulated by the Food and Drug Administration or the FDA. And the FDA regulates any research that utilizes a product such as a drug or a biologic or a device. So that's one type of regulated research. The other type of research that's regulated is research that is supported or conducted by a common rule department or agency of the federal government. Now obviously saying that something is conducted that's pretty clear. But when we talk about supported what that means is that if one of these agencies gives funding in terms of money or in terms of some other assistance towards the research project, that that research then is regulated by that department or agency. So I think the key point here is to realize that not all research is regulated at this time. There have been a number of examples out there. There was one of a plastic surgeon and he decided he wanted to use a different technique this time than he had used in the past. And so on this particular woman, half of the face he used one technique and the other half of the face he used his original technique. There was no informed consent obtained from this person, they didn't understand the risk of the research and what he was doing and probably didn't even identify it as research. So that's an example of something that actually occurs today that is not regulated by either the FDA and because it was not funded under a federal agency would not be regulated by them. So just to understand what research is regulated. Now to the next slides and you know I mentioned that there are these departments of the federal government that have these regulations and you can see from this slide that actually as of today we list 18 departments or agencies because now the Department of Homeland Security is also included. And what we're talking about here are the basic protections for human subjects. And we often call those the common rule because you'll see that in 1991, a number of these department or agencies all adopted these regulations and so these are the regulations that are the foundation for human subject protections. Now, to the next slide, we're going to start talking about of all those agencies. I'm specifically going to be speaking about the Department of Health and Human Services. On the next slide you will see that under the Department of Health and Human Services there are a number of agencies that do conduct research or fund research and I've listed a number of these agencies on the slide. Probably the one you're most familiar with would be the National Institutes of Health or NIH. Certainly CDC and as you heard before the Indian Health Services. But a number of agencies are on there. So these are the agencies that would, as you go to the next slide, you would see that these are the agencies that would fall under the Department of Health

and Human Services regulations for the protection of human subjects. And these basic protections we often refer to them as sub part A. Now these were originally adopted in 1974 and I like to always remind people that the latest version of these you will find dated with June 23, 2005. So if you are a person and involved with human subject protections you want to be sure you have the newest version. In addition to sub part A or the basic protections, under the Department of Health and Human Services, there are additional protections. So if you'll turn to the next slide you'll see that there are protections for three types of vulnerable populations. The first is sub part B and that's additional protections for pregnant women, human fetuses and neonates. Sub part C provides additional protections for prisoners and sub part D additional protections for children. So if research is conducted or funded by the Department of Health and Human Services then the institution must comply with all those regulations. Now I'm turning to the next slide and it's one that's not very easy for you to see but I wanted to sort of give you a global picture. And move to the next slide which is a little easier to read and where I sort of extracted the piece that's important to us today so that you can start learning a little bit about the Office for Human Research Protection. You can see there that under the Department of Health and Human Services we have the Secretary, Secretary Leavitt, appointed by the President. Under the Secretary we have the Assistant Secretary of Health and that's Dr. Agwunobi. Dr. Agwunobi has the Office of Public Health and Science and the U.S. Public Health Service Commission Core. And it is under the Office of Public Health Science where OHRP sits, so you can see from that diagram. We were moved, as many of you probably know, in 2000, after the death of Jesse Gelsinger. Donna Shalayla was the secretary of Health and Human Services at that time and she moved the Office for Human Research Protections from the position that it was in previously, which was within the structure of NIH. And she thought that there was a potential for conflict there since NIH was the largest funder. So were moved more directly under the secretary and I think this shows the level of importance that the department gives to human subject protections. Now looking at the next slide you'll actually see an organizational chart for the Office for Human Research Protections. And I know that might be a little small for you to see but let me just quickly say that under our office there are three basic divisions, the Division of Policy and Assurances. And you're going to hear me talk a little bit more about assurances but this division is involved in working with institutions to obtain an assurance and also to develop new policy and guidance for the research community. The next division would be the Division of Compliance Oversight. That's the one that most of you have heard of if you hear about our office because this is the office that does investigate allegations of non-compliance and is involved in the suspension of an assurance such has happened to a number of institutions in the past. And then the Division of Education, and that's rather self-explanatory that our role is to help institutions and folks involved in human subject research under the Department of Health and Human Services, that they would better understand the regulations and the policy. So as Paul Harvey has said in the past let's get to the rest of the story.

So turning to the historical perspective related to human subject protections. You see that the first slide is a slide that shows the Nuremberg Doctors' Trial. Now most people think this is the beginning of modern history of human subject protections, that after

World War II there were a number of trials but one of them was the Doctors' Trial. And you see here that 23 German doctors were charged with crimes against humanity, that experiments were done to human subjects and that in the course of these experiments that there were murders committed, brutalities, cruelties, tortures, atrocities, etcetera. As the trial went on they realized there were no standards that had been documented in terms of human experimentation. So as part of the verdict, turning to the next slide, as part of the verdict the court set forth standards then that should be in place for human subject experiments. And you'll see three of the important ones that came out from the Nuremberg Code at that time. The first one being that there should be voluntary consent, that the benefits of the research must outweigh the risk and that the person has the ability to decide that they no longer want to participate in the research or terminate from the research. Now turning to the next slide, I think one of the things that's important to remember that as these things occurred, we saw them as things that would not happen in most settings and so people were not really thinking much about the Nuremberg Code even though it was in place.

I've listed here that the Thalidomide Tragedy as another important weight in time. You see from the slide that it was, there were thousands of birth defects that occurred in Europe. This was happening in the '50's and '60's, it was actually in 1959 when an American company got the right to distribute a drug that was already being used in Europe for morning sickness in pregnant women. But there had not been any research done as to how this would effect a fetus. And you can see here that it was the FDA's medical officer, Dr. Francis Kelsey, who had some great concerns about this particular drug and although it was already being passed out to physicians in America so that they could distribute it to their patients, she had great concerns about approving this drug. And in about 1961 some of the reports started coming to her that gave her great concern about this particular drug. And as most of you know, it was in the first trimester of pregnancy is when the organs are formed in the fetus and so many of these children were born without their limbs. You can see that in 1969 then it was at that time that there was the Kefauver-Harris amendment to the Food and Cosmetics Act. And this was very important because it now required that all drugs had to be approved for not only the efficacy but also the safety of the drug. In 1964 in the next slide, this is important because the World Medical Association decided that we needed to have some guidelines for research involving human subjects. And you look there and you'll see on the slide that it says that there must be concern for the interest of the subject and this must prevail over the interest of the science in society. So this was a strong statement now coming to the physicians that were involved in research.

Moving to the next slide. In 1966 Henry Beecher's article in the New England Journal of Medicine on "Ethics and Clinical Research." So even though some of these things were starting to come out about the protections that should be in place, Dr. Beecher identified 22 medical studies that presented risk to subjects without their knowledge or their consent. And that these research studies had been published in very prestigious journals and many had been conducted at prestigious institutions. Turning to the next slide you'll see a couple of examples that I've put down here, some that are very familiar, the Willowbrook School in Staten Island, New York. This was an institution that took

mentally retarded children. It was, as most were in those days, very full, it was hard to get your child into the institution. So the parents were told that the way that they could get their child into this instate institution was if the child came through the Hepatitis Unit. And the way that this would happen would be that they would be deliberately injected with the hepatitis virus and this would allow them then to be housed in the institution, so you can see there was some coercion there in that situation. The next one I have down is the Jewish Chronic Disease Hospital and that's in Brooklyn, New York and you see here that it talks about they injected live cancer cells into non-consenting elderly subjects. And then the Milgram study. If most of you've heard of this this is the one where they were testing memory and learning and the theory was that if you punish the learner that they would learn better and this was done by supposedly giving painful shocks to the learner. This was a study of deception. The people that were giving the shocks didn't really know that in fact the subjects were not getting them but they were told to increase the voltage of the shocks and if the person didn't answer right that they would increase the voltage to the point that it actually could have been fatal. Actually 60% of the people in the study gave shocks up to 450 volts, in theory, in reality they were not, it was, as I said, a deception study. And then finally the Tea Room Trade study in St. Louis and this was a study where there were homosexual encounters in a men's room in public places. A man posed as the person watching out and after getting information later went to some of the folks' homes that had been in the public place and breached their confidentiality. So these were some examples that were pointed out as being conducted in the United States and of being of great concern. Now as we go to the next slide, moving along, you will see that here we have a Public Health Service policy. Now policy isn't law but in 1966 the Department of Health Education Welfare, which was the precursor of the Department of Health and Human Services, they issued policies for the protection of human subjects. And going to the next slide you can see that there were requirements for anyone then that was getting funding, any grantee, that three topics now needed to be addressed by a committee prior to the start of the research. And they mentioned that there needed to be discussion of the protection of the rights and welfare of the subjects, that there was appropriate methods of informed consent that would be utilized and that they need to look carefully at determining the balance of the risk and the benefits. So here we start to see where the federal government now starts to put in policy to ensure the protection of subjects involved in research that's funded by the government. And this is where we start to see the beginning of the IRB. Turning to the next page you've already heard about the U.S. Public Health Service Syphilis Study. Now it was in 1972 that a reporter exposed this study that had been conducted by the US Government for a period of approximately 40 years and it was conducted in Macon County, Alabama. And as many of you know this was a study where they were looking at the course of untreated syphilis in African American men. And many people think of this as the Tuskegee study. The subject in this study did not know that they had syphilis and I think one of the things that you'll see comes about later in our discussion, one of the things that was very important here is that even when there was a treatment for syphilis they were not offered that treatment. Now when this story broke this was something that really caught the nation's attention and you could see that on the next slide Senator Kennedy put forth hearings on the quality of healthcare in human experimentation. From these

hearings came the National Research Act and as part of that act you see two things. One, there was established a National Commission for the Protection of Human Subjects and that they required IRBs at institutions receiving support from the Department of Health and Human Services. Going to the next slide, this commission met on many different topics but the one that we want to focus on here is called the Belmont Report. It set forth the ethical principles and guidelines for the protection of human subjects and this report came out in 1979. Now turning to the Belmont Report, it put forth three basic principles. These basic principles were the respect for persons, that we always need to remember that the person has the right to make an informed choice. And for some individuals who have reduced autonomy, that we need to ensure that we have additional protections for those individuals. The second principle was beneficence and that is that it is our obligation to maximize the benefits of the research and minimize the harms. And the third principle, justice. And in this situation we're not talking about our court system, we're talking about the fact that in the past, as you saw from some of those studies, it was the people who were poor, who were institutionalized, who were in a lesser situation in our society that often bore the risk of the research. But then it was the more advantage who actually benefited from the research. So this brings to mind that we have to think about the folks that we are including in our research studies as we do our recruitment. Now, the Belmont Report, the commission was going on and they were talking about all these things but the next thing that was happening in terms of legislation actually occurred then in 1974. So you can see a lot of things were happening during the same time period. And it was during this time period that the regulations for the protection of human subjects, remember that we now talk about it as HHS but then it was DHEW. They issued regulations and these regulations, when we talk about them, they are codified under 45CFR part 46. These basic protections, going to the next slide, there are three main basic protections that are in these regulations. The first one being the institutional assurance, the second IRB review and the third informed consent. So I'm just going to talk about each one of those briefly. In terms of the first protection the regulations say that an institution that is engaged in human subject research that is conducted or supported by the Department of Health and Human Services, they must sign a written agreement. And this written agreement is their commitment to comply with the regulations for ethical research. So that's the first protection, that the institution itself is going to make a commitment to ethical research. The second protection is an institutional review board and I think we all know what that is but just as a reminder they are charged with reviewing the research to assure that the rights and the welfare of the subjects are adequately protection.

Now, why do we need an IRB? Well, in very simple terms, I think it is the fact that it's very hard for any of us to really be objective about something that we're working on that we've got a commitment to and we need a group of people that can be objective to look at this research. And in addition, I think the other thing is that when we're involved in something and we know it very well, we tend to minimize the risk. As a nurse, who started many, many intravenous in my career, I don't find that to be a very risky thing. I know about it, I understand why we have a long needle that we use and so forth but that's because of my experience. And so someone else less experienced with it may have greater concerns about the risk and justifiably so. The regulations say that the IRB must,

and this is going to the next slide, they must do a review prior to the initiation of any research activity. So that's the first protection, is that they must review it before anything can start. They also must review the research any time the research changes. And then thirdly they must review the research, we call this continuing review, but they must review this research appropriate to the degree of risk but not less than once per year. And this is when you'd look to see have there been changes in the research that should stop the research or should the subjects be given additional information. This would go back to the need for continuing review back in the syphilis study as that research changed. And then the third protection, and wrapping up, and the third protection informed consent and this is key. We have to give the subjects full disclosure of the nature of the research and of their participation. And they also must be able to understand the information. So we have to be sure it's in a language that's understandable and that they comprehend the information. And then the third point is after we've given them this information and they understand this information, we must ensure that the participation is voluntary and that there is no coercion to their taking part in the research. And then to the next slide as a wrap-up here, although we're just starting to talk about those protections within the regulation and they're very important. But for all of you out there in whatever role you're in, I just want to remind you that the most important thing is that protecting human subjects is a shared responsibility and each one of us involved, no matter what our role, we are obligated to help protect these subjects. It is a privilege to do research, it is not a right to do research. And then my last slide, I just list you with some contact information and also to remind you that OHRP has a web site that not only contains the regulations but guidance and some frequently asked questions that people have been finding very helpful. You can e-mail us at any time with questions. There is an e-mail box that goes to our office. We have a toll free number. And if you want current information when we come out with something new or we're having an educational program, you can join our list serve and you will automatically be e-mailed information from our office. I think you for your time and attention and I hope this has given you a good basis to move through your next series of discussions.

Vanessa Northington Gamble: Thank you, Shirley. Our next presentation is going to be from Bill Freeman who is going to be using a case study to examine some of the issues that Shirley brought up in her presentation about how to protect individuals and communities involved in research. And after Bill Freeman's presentation we will open up the lines for questions. Bill?

Bill Freeman: Thank you very much Vanessa and Shirley, for the fine presentation and the kind words, Vanessa. The case study was written by Dr. Francine Romero who was for many years the co-chair of the National Indian Health Service IRB and then was chair of the Portland area Indian Health Service IRB which was actually the IRB for the 44 tribes of the Northwest Portland area Indian Health Board in the three states of Washington, Oregon, and Idaho. I was chair at the time when she was co-chair of the national and we worked well together and this is actually a case study of something that I was involved in in the research as well as Dr. Romero. Depending on how you're looking at the slides at the power point, if it's a full screen, some of you may find that individual elements come in at, you have to click to bring in each bullet, so I will say

click to bring in a new bullet. But I will try to remember to say next slide to go to the next slide. So the first slide just has the title, go the next slide, it's learning objectives. Click. It's to identify elements essential to protect individuals and communities. This is the important part, and communities involved in research using this case study. Click. Understand the procedures for approval of research in Indian country. Next slide. Three basic ethical principles. This is a review from Shirley's slide very briefly, respect for persons. Click. Click again, I'm sorry. The application is informed consent of individuals among other things for that principle. Click. Beneficence, that is do good and don't do harm. Click. And the application of that principle is assessment of harms and benefits in the research to both individuals and communities and then minimize harms and maximize benefits. Click. Justice is a third ethical principle. Click. Selection of participants in research is the application of that. Well in fact we also think, although it's not in the regulations. Next slide. There is a fourth basic ethical principle. Click. Respect for communities. Click. And the application of that is the community involvement and participation in all phases of the research as well as in the review of the research that often is otherwise done only by say a university IRB. Next slide. This is a case study of diabetes screening, screening for diabetes and pre-diabetes. Next slide. The case study is the reason for the research was high prevalence to Type II diabetes, which also used to be called adult onset diabetes or non-insulin dependent diabetes. That is caused often, has risk factors related to behavior in various ways, especially eating more, exercising less, being heavy or obese. And that includes children. Children are at risk now for Type II diabetes, as well as developing in early adulthood, Type II diabetes, with these risk factors. So the research was a community-based screening of school children in primary and secondary school. I believe, if I recall correctly, it started at about the fifth grade of school children, as well as other things. Next slide. The research looked at the community, so factors related to preventing or not promoting healthy lifestyle. For instance, if you're promoting walking as a way of exercise you need to have safe streets, the reservations, sometimes that's a major problem. These are rural roads so things like sidewalks or fitness centers. The schools, looking at the schools aspect. Did they have healthy lunches? Did they have junk food machines for dispensing and soda pop machines? Family activity, such as did the family do exercise...physical activity together and individual assessments. And these were off, because they were children, were actually less in terms of questions and these were physical assessments. So height and weight to determine degree of obesity or heaviness or fatness but also then things like skin fold measurements, that's a way of measuring what is the layer, thickness of the layer of fat around the abdomen. They also looked what's called acanthosis nigricans, which is a marker of the skin or darkening of the back of the neck for many people in early pre-diabetes for many children and also adults. As well as blood tests to determine, do they actually have diabetes, did they have pre-diabetes, in other words were they at risk to develop diabetes and so on. This was research that was, took a system-wide approach to look at in a very comprehensive manner. All the factors that are responsible for or lead to or contribute to Type II diabetes looked at the resources available that were currently being used, looked at communication, health education and so on. So this kind of research actually has significant issues of human subjects protection and because of the vulnerable subjects. And the vulnerable subjects can be

considered in two ways, one was the children themselves so they needed to have assent forms, which the original research didn't have, the original research proposal. And, a process to get the assent of these children as well as, of course, parents' permission to be in this screening. But also then the community protection, the community is vulnerable. This particular reservation, as many, has shall we say less than 100% acceptance by the surrounding community of the majority society. And depending on the way things are done and what was presented it could be a reservation community in a very bad light. Next slide is the National IHS IRB. Click. This IHS IRB requires tribal approval for all research and publications due to concerns of tribal sovereignty. Click. It tries to be sensitive to cultural appropriateness of the study design, questions and implementation and tries to incorporate in the IRB itself community specific knowledge, norms and world views. We have, have been and I believe still do, 70% of the IRB members were native, were American Indian or Alaskan native and that included both PhD people like PhD in genetics for Francine Romero as well as MD's, RN's, etcetera. As well as community members, lay people who were tribal members. Next slide. National IHS IRB again. Click. Minimize adverse impactful research by minimizing potential harms and maximizing potential benefits to individuals and the community. And this was the role of the, in this particular case study, of the IHS IRB. We were very concerned about stigmatization. First of all, stigmatization of the children, of the individuals who are being examined. You know how kids are, we all know how kids are, they'll take anything as a club to attack other kids, verbal club. So we were concerned that some kids might be identified as being real heavy or having acanthosis nigricans or being pre-diabetes, that that would get out to their peers in school and they would be ostracized or stigmatized. So we made sure it was not in the original proposal to deal with that, prevent that by confidentiality, stronger confidentiality issues, having the exams not in the full view of everyone else but in closed space so no one else could see that, etcetera. As well as have counseling for people who were found to have a problem. In other words, getting a diagnosis of say having pre-diabetes is itself a real problem in terms of, or a potential problem in terms of the person's own self image of themselves and so on. But we're also concerned about stigmatization of the community. So you could imagine, depending on what data were obtained in the study and how it was presented to the public it could be either well, this community is just unhealthy, it doesn't have this, that and the other thing to promote healthy lifestyles and it's causing their kids to be obese and so on, all negatives. Or it could take the very same data and present it in a this is a problem to be resolved that the community is working on, the community is working on improving these aspects. As well as that the community is the first one to find out what the results are so they can do something. This is not for national publication although it will be published nationally, the primary purpose is to help the community. Click. The basic ethical concerns with promoting research, excuse me, balances ethical concerns or regulations with promoting research. This is important and we often forget that the reason IRB's are in existence and they reason we have regulations is first of all that we think in general research is a good thing but it has to be ethical, it has to be good research, not bad research. So we agreed with that and what we were concerned about as the IH IRB is not to be an obstacle or an impediment to good research but just the opposite, although some researchers may disagree occasionally with this. We want it to

enhance the communities role in research, in other words to have the research be more community-based participatory rather than less that it often was presented initially. And the reason is because we felt that the community would know more than the IRB about what were the issues, what were the potential problems, what were the potential harms and how best to deal with those, to prevent those and also how to maximize the benefits. We're not from that community, in spite of having 70% American Indian, Alaskan native membership. So we're trying to enhance the communities' role. You will find that one of the later sessions, I forgot which one, it might be number three of this series of sessions that may be a case study where the IRB seemed to be more of an obstacle. This case study shows that in fact it can be a enhancement of the community, of a community-based participatory research approach. Next slide, research approval in Indian country. Do a series of clicks. Tribal health director, tribal health community or board. They typically, each tribe has a community or a lay board overseeing the health program. Tribes have their own IRB's. Navaho is mentioned here. Choctaw, Chickasaw, Cherokee and Oklahoma. Alaska area does, all the tribes have gone to, all the Alaskan native villages have gotten together and helped corporations. Portland area also. Tribal council approval, this is the tribal government in other words. The host institutions IRB, in other words the IRB of the, assuming it's a university or an institution, the research is from some other institution. That institution's IRB, the research is used to getting that. The IHS IRB, I already mentioned Alaska and Portland area covering Washington, Oregon and Idaho as really being tribal-based, and the national IHS IRB. Fine Leaf Cost Funding Agency doesn't necessarily have an IRB approval but they won't fund things that they don't think is appropriate or whatever, an IHDCDC. So you notice that there are eight approvals needed in Indian country, whereas most research elsewhere has in this list only two, the researches host institution IRB and funding agency. And the reason for all these others is in fact the involvement of the community to enhance that and promote that. Next slide, tribal researcher relationships. Click. Understand and appreciate community research priorities. What are those priorities and are they the same as researchers? Well not necessarily, although I think researchers can well fit in them. One priority is to solve problems for that community. It is not to have a national publication. So we insist that the, and we want the tribes to insist, by their approval process, that the research first be presented to the tribe, to the tribal council or health board or health program so that problems can be solved. We also are concerned about not making things worse and this is where, again especially, the involvement of the community in the process of the research itself is so important. So in this case study the whole issue again of stigmatization of individuals, what we did was to, as the IRB, make sure that that was managed and that included self-stigmatization. Again of, "gee, I'm labeled as fat." What do I do as a 12-year old kid in relationship to my self-image; am I defective or a bad child, how to avoid that, but as well then, stigmatization of the community? We don't want these communities to be in fact made worse by the research in terms of how it's published and what happens. I'll just give one example where that is the case. I'm not speaking behind anyone's back, CDC recognizes that this is a case but you may remember hantavirus, a bad virus and it was fatal about half the time and epidemic began in 1993, that's when it was discovered, it seems like it's been around a long time. But it was the first two publications after the Navaho Nation Department of Health asked the

CDC, that did wonders, but not to use Navaho place names in the reports. The first two reports gave Navaho place names where people died, the small villages or chapters and where the deer mice were captured, that showed the highest rates of having hantavirus. That was very inappropriate and was damaging to the Navaho people. Click. Community partnerships from inceptions of idea to community completion and into publication, I've just mentioned that. Understand and appreciate tribal interests. Again, it's not the IRB that does it, we want the tribe and the researchers together in some sort of a, in real partnership to produce this understanding and appreciation. Regular and timely tribal consultations. Click, I'm sorry. Click again. Community capacity building benefits to the tribes. Click. Help tribes understand collaborative responsibilities. Next slide is tribal researcher relationships, again, continuing that. Some additional things that we try to promote as the IRB is to make available to the tribes a listing of all public health resources to tribes, provide technical assistance to tribes by the researchers, develop training and linkage opportunities to ensure better understanding of tribal and community-based tribal health systems. Last slide. This again, the PowerPoint presentation by Francine Romero. You have her contact information including her new position. She was literally at the last minute suddenly not able to participate, she really had wanted to. I'm the verbal presenter, you have my contact information, I hope I did her a justice. I will add just one thing about Francine. She is a mentor to me about how to be ethical, an ethical researcher, when she was faced with some difficulties. Thank you very much and let's have Vanessa, back to you for questions.

Vanessa Northington Gamble: Thank you, Bill. And I'd like to open it up, the lines open for questions now. But I also want to thank many of you who are registered for this conference who submitted questions. During the course of our six conversations, we'll try to get to as many of the questions as possible. We will not be able to get to all of them today but as we gear up for questions I want to ask you a question, Shirley, that was submitted by one of the people who registered for the conference call. And this question was from someone who was interested in the composition of IRB's. And the person wanted to know who gets to serve on an IRB? How are they chosen, and what are the competencies for someone to join an IRB? And you can answer this as we gear up to get other questions from the audience.

Shirley Hicks: Sure. The regulations, and again I think probably this is something that will be discussed in a little more detail on the next call but the regulations clearly outline the members of an IRB, the qualifications that need to be there. So I'm going to speak generally to the question that you asked. In terms of the selection of folks for an IRB and their qualifications in terms of a specific IRB, generally it's the institutions policies and procedures that establish that. So for example, an institution, it might be the vice president of research who actually determines who the IRB chair will be and then maybe it's the IRB chair who actually identifies who will be the members of an IRB, or it could be a committee. So it really is very individualized from going to different institutions, I would say that it varies a great deal on who makes the selections and what kind of an IRB it is, is it by a medical, is it social behavioral, what type of expertise do they need on that IRB for the type of research that they review. And then the regulations clearly say there must be one non-affiliated member that is not from that institution that represents the

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community and all of the regulations only speak to having required one. Many institutions, and as you were talking about community members and such, many institutions are calling this a community member and are reaching out to more than just one on their IRB. I hope that answers the question.

Vanessa Northington Gamble: Thank you.

Operator: Thank you. And at this time as we begin the question and answer session, to ask a question please press 0, followed by 1, on your touch tone phone. Questions will be answered in the order they are received. If you have a question press 0, followed by 1 now. And please hold for a moment while our system compiles your responses. And our first question comes from ---. Please go ahead with your question.

Caller: Yes, this is ---, I'm just calling. Mike, this was a very useful review. There were a couple of the studies that we were not aware of. I wanted to ask a question about a practice and a former institution. It was the distinction between active and what I call passive consent. There were several researchers at this university who were afraid that if they asked parents to sign something and send it back to them that they would not get enough responses. So they instituted a thing called passive consent where they said if you don't send us anything back then that is a consent. And I thought that was a pretty weak fulfillment of the informed consent and voluntary participation rule and I just wanted to know you felt about it?

Shirley Hicks: Well this is Shirley. Basically the regulations do not recognize anything such as the term passive consent and we do hear people talk about passive consent. The regulations talk about having a signed consent, they talk about the consent process. One of the things that the IRB does have the right to do and [unintelligible] has been on an IRB and maybe he could [unintelligible]. But if it is determined that it meets criteria, consent or a documentation of consent can be waived. So depending on the research project the IRB could have made a decision to waive [unintelligible] form consent.

Caller: Well, let me tell you a little bit more about, part of the problem was that this hugely involved access to student records. So it typically did not involve actual experimentation with children, it was access to their records or in some cases filming a classroom in action. So there was no direct and immediate harm to the kid and so I think that was why the researchers went this passive consent route. But I still thought it was a rather weak fulfillment of the requirement.

Shirley Hicks: Bill, do you want to comment on this?

Bill Freeman: Yes. Shirley is correct, passive consent is not consent period, end of statement. It does have to, it's possible for an IRB to waive consent and that possibly was possible then, I don't know. But more importantly, there are also ways of increasing the number of parents that will respond. I mean most of us get stuff in the mail and it goes down at the end of the, the bottom of the pile by the next day and we don't get to it, so you have several mailings. We can talk later, you could e-mail me. If any IRB is

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concerned about how to help researchers increase in fact their active obtaining of parents permission. It's possible to do and actually honor then the parents permission or consent.

Caller: Okay, thank you.

Shirley Hicks: Thank you very much.

Operator: And our next question comes from ---. Please go ahead.

Caller: I wanted to first ask is it typical if you're doing research on a college or university campus that you go through that campus' IRB?

Shirley Hicks: In general I would have to say yes. If you're doing research at an institution then you need to contact the human research protection administrator at that institution regarding any research that you're doing. Remember that the regulations are sort of the floor and they're not the ceiling and institutions can layer additional requirements. And so even though maybe it doesn't, might be exempt from the HHS regulations, your institution may have a policy and procedure that says that they want to see everything, even if it is exempt. So I would say in general my answer would be yes, you need to contact your institutional review board, human subject protection administrator person.

Caller: And it's just a second part of that question. If it's a small college and doesn't have its own IRB, what are some other options? Would be a community-based IRB or is it possible, what are some options?

Shirley Hicks: Well if you're doing research, research is to be reviewed by an IRB and so your institution may have an agreement with another IRB that's not housed within your institution. It might be at another university, it may be at an independent IRB. There should be someone within your department chair, the vice president of research. You should be able to find someone within your organization to ask about the appropriate procedures if you're wanting to conduct research at that institution. Bill, any other thoughts from you on that one?

Bill Freeman: Yeah, I would agree with that. I have nothing else to add.

Caller: Thank you.

Shirley Hicks: Thank you for calling in.

Operator: And our next question comes from ---. Please go ahead.

Caller: This question is for Miss Gamble, Dr. Gamble. I'm a pediatrician and I participate here of the IRB as a committee member and I'm also interested in minority health. And I think reading your bio. It looks like you may be able to answer this, perhaps add some insight into what's going on from the perspective [unintelligible] development with regard to the Tuskegee study. Minority participation in the current era,

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how has this Tuskegee study impacted current research enrollment of minority participants?

Vanessa Northington Gamble: Well first of all, I prefer to call it the United States Public Health Service Syphilis Study. And the reason why I call it that is that because many people think that it was Tuskegee University, then Tuskegee Institute that conducted the Syphilis Study as opposed to the federal government. So that's my new campaign to have it be called US Public Health Service Syphilis Study. And I think that the Syphilis Study has had some impact but it cannot be the only prism through which we look at the relationship of minority population in biomedical researchers. I think that for some people it has had an impact but not for everyone. And I did a study several years ago when I looked at the relationship of African Americans and researchers and found that there were issues of lack of trust before the syphilis study. So I think it's important but I think that we cannot stop there, that we have to figure out what else is going on. And I think for many African Americans that how they feel about the healthcare system is in large part effected by their day-to-day lives and their current interactions with the healthcare system. So I think that we can't just look at the syphilis study. And Harriet Washington in her new book, *Medical Apartheid*, has really looked at this in detail of the relationship of African Americans and researchers.

Caller: Thank you.

Vanessa Northington Gamble: You're welcome.

Operator: And our next question comes from ---. Please go ahead with your question.

Caller: Thank you and good afternoon. The question is really coming from --- who will take it out from here.

Caller: I very much enjoyed the clarity of your presentation and your example of the cosmetic surgeon who gave two different or used two different methods on two different sides of a face of a patient, made me think and wonder about why it is that certain kinds of research are exempted from these kind of oversight committees and given that the abuse of the human subject violates that subjects rights, regardless of where the research occurs, why is the regulation and oversight of research limited to federally funded research or research that falls under FDA rules?

Shirley Hicks: Well that's a very good question. And after one of our recent research disasters there were bills put into both the house and the senate that would put forward regulations to oversee all research. Those bills didn't make it through and of course with all the things we have going on right now within congress with the war and so forth they're probably not high on the list right now. Unfortunately I guess what I would say is that probably when the next disaster happens then the awareness will be increased and something might go forward again. We realize that that's the way it is with many things in life, whether it's an airplane crash or whatever, the response happens after some

disaster. So it was put forth before, it may come forward again but for right now this is the state of regulations.

Bill Freeman: Let me also, if I may add a couple of things to the first question. There are some kinds of research that is so unlikely to be risky at all to anyone, that's the category where they're exempt. So for instance, a survey that's of adults that is totally anonymous, where the idea is that no one, because no one is identified no one can be harmed, is one of those categories. That's different than a surgeon obviously choosing to do a face, a reconstruction are two different ways, which is a bizarre approach. I think we all agree as well is totally unethical. So that's the category but let me also say a couple of things. First of all, the institution can actually raise the floor, in other words what the regulations say is it is not necessary for the IRB to review these. It also in the agreement with the federal government an institution can, and most of them do, say that we will review, we the IRB or the institution says our IRB will review all research irrespective of funding. So that although it is possible to have research, as Shirley gave that example, at least at an institutional level, an institution can go beyond the regulations and the limitations to those regulations. Everything is a floor, not a ceiling. I hope that helps answer it. By the way, it is also true that one can imagine and I haven't seen it but where some of these categories of what is except actually in a real situation, could be harmful. Consider a survey of women, all women in a town of voting age where they get cold turkey and a letter that says here is a questionnaire and they start asking about their experience of having been abused sexually as children. Well, that can adversely affect some people, the questionnaire itself. And I would not consider that exempt because it is greater than minimal risk.

Vanessa Northington Gamble: Thank you, we have time for one brief question.

Operator: And our final question comes from ---. Please go ahead with your question.

Caller: Thank you. One of the questions I have regards establishing, there's more movement for tribal IRBs, for tribal entities, like Navaho has their own IRB. I'm wondering how that will work with the other regional and national IHS IRBs in terms of when you go through the process would you continue to go through the process of IHS as well as your local IRB, is that something pretty standard?

Bill Freeman: It will depend. The circumstances are that, first of all, the local IRB, the tribes IRB, if the tribe has one and certainly the tribal council as well, always control. So that they can veto a research, so that then the IHS IRB may be involved in the following two ways. First of all, if the IHS is involved in the research in any way, either doing it or more likely in this case from your scenario or what you're asking about, if you're using IHS resources such as looking at IHS charts, etcetera. But if they're not, if IHS is not involved in any way, the only other reason that IHS IRB would be involved is if the tribe wants it to be involved or the tribal IRB wants it to be reviewed either as an advisory or as an actual, a full IRB review.

Caller: Okay. And then another part of that was you were speaking to the community protection. Is there any talk of that becoming more formerly part of the IRB regulations at a federal level, since those three protections focus on individual often and this movement toward community protection and I'm wondering if there's any thoughts about formalizing that?

Vanessa Northington Gamble: We're going to be talking more about that as we go on. Because what I was about to say and this is a great segway, was that what was interesting about the presentations was that Shirley really talked about, when she was talking about the history of the regulations she really focused on that it was for individual protections. And Bill talked more about how do we get community protections. So as we go on with the series, we will be talking about these issues, about how do we move towards more community protections. So that's a nice question for us to end this call today. And I want to thank everybody for participating and especially our speakers, Shirley Hicks and Bill Freeman. But I also would like to, at this time, thank Kristine Wong and Jessica Grignon for keeping us on point and organizing this conference. And I look forward to hearing from some of you as we continue this series and the work that the Bioethics Center will be doing with CCPH. And with that, I'd like to turn it over to Kristine Wong.

Kristine Wong: Thank you very much, Vanessa. So before we wrap up, I'd like to let you all know about some upcoming opportunities listed on a slide you received in the handout. As you can see here, registration is now open for CCPH's 10th anniversary conference in Toronto in April. Nominations are due this Friday, February 16th, for the CCPH annual award. Applications are due March 15th for our 10th summer service learning institute taking place in July. And applications are due April 1st for the summer community-based participatory research institute this June in Jackson, Mississippi, being sponsored by the historically black colleges and universities' faculty development network and Tougaloo College. Please visit our web site for more information. So once again I'd like to give a thank you to Dr. Northington Gamble, Shirley Hicks and Dr. Bill Freeman, as well as to all of you out there for calling in and participating in today's call. I'd also like to give special recognition to CCPH's graduate research assistant, Jessica Grinyoung, who played a key role in organizing today's call. We hope that you will take part in the rest of the call series. As you mentioned earlier our next call is going to be on the non-affiliated IRB member. That will be on March 14th, starting at 12:00 PM, Pacific Standard Time. And registration is now open for that call, so please visit our web site. For a full description and schedule you can also visit the same page and I hope that you all have a nice day and take care.