

## What Will It Take to Get IRB Reform?

**A**LTHOUGH MANY VOICES are joining together to call for reform of regulations governing institutional review board (IRB) oversight of research involving human subjects—and some of those voices even agree on how the IRB process should be reformed—progress in the United States toward such reforms is glacial. Unfortunately, the foot-dragging on reform may be costing the United States its leadership role in health research.

Current U.S. regulations governing protection of human subjects have their roots in the 1960s and especially the 1970s, when the National Research Act became law in 1974, spurred by the publicity surrounding the Tuskegee Syphilis Study. In that famous study of black males observed from 1932 to 1972, investigators denied penicillin to infected men. The National Research Act prompted the creation of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research.<sup>1</sup>

Now, almost 40 years after enactment of that law, the U.S. health system is evolving faster than the rules to govern it. For example, how do we best regulate comparative effectiveness research (CER)? CER is a hybrid of both clinical trial research, which requires an IRB, and quality improvement processes, which are typically IRB exempt.

Electronic medical records also present a challenge. For example, the President's Council of Advisors on Science and Technology recently released a report<sup>2</sup> that on the one hand recommends personally determined data tagging and stresses the need for privacy safeguards, while on the other hand advocating the recommendation of the recent Institute of Medicine report<sup>3</sup> to permit greater access to health data to facilitate research.

It is no wonder that the U.S. government provides inconsistent recommendations. In addition to the Food and Drug Administration, 19 other federal agencies are involved in oversight for protection of study participants. There are more than 6,000 IRBs registered with the Department of Health and Human Services.

Inconsistent outcomes appear to be increasingly likely when the same protocol is presented to different local IRBs, as is common in a multicenter trial.<sup>4,5</sup> One study of 88 pediatric practices found that local IRB review appears to be a barrier to participation in research, "may discourage the inclusion of minority and urban patients, and seems to result in little if any significant change" in the (minimal risk) protocols.<sup>6</sup> Pogorzelska et al.<sup>7</sup> are among the many calling for local IRB reform, including clarification of specific purposes of local review (e.g., ensuring cultural appropriateness), assurances that IRB members are trained in regulatory requirements, as well as ethical principles of

research, and consideration of central review mechanisms. This latter is perhaps the most controversial, as national, independent IRBs have been reviewing federally funded research only since 1996.

Five concerns with using an independent IRB are: (a) a perception of increased risk to the institution; (b) possible conflicts of interest among the sponsor, site, investigator, IRB, and IRB member; (c) the importance of local knowledge; (d) logistics between the IRB and the site; and (e) the cost of administrative support. Coleman<sup>8</sup> opines that careful evaluation of the following factors will lead to appropriate use of independent IRBs: "the IRB's reputation and references; composition of the board committee(s) and qualifications of committee members; access to scientific experts; accreditation status; support staff quantity, qualifications, and training; results of regulatory inspections; approval stringency and typical letters; meeting frequency; operational metrics, such as review times; and operating procedures, such as internal auditing and error handling."

Regardless of whether a local or independent IRB is used, some say that IRBs concentrate on the wrong things and consequently do not do a good job of protecting the patient. A small e-mail survey ( $N=28$ ) of principal investigators<sup>9</sup> revealed that respondent PIs felt that consent forms were incomprehensible, that IRBs focused on minutiae, and that they were more concerned with protecting the institution than the subjects. Problem areas and solutions proposed by the Infectious Diseases Society of America<sup>10</sup> not referenced earlier in this editorial include:

- Health Insurance Portability and Accountability Act (HIPAA): Remove research from list of HIPAA-covered activities;
- Studies including children: Provide updated guidance for key terms, make national review outcomes available and streamline the process;
- Office of Human Research Protection: Provide increased funding and a clear mandate to produce timely updates in guidance and review.

Another suggestion made by Kim et al.<sup>11</sup> is to stop regulating minimal risk research, which represents 41% of all new protocols reviewed by U.S. medical center IRBs at a cost of about \$300,000 per year for each review.

Many of the solutions suggested by our colleagues are regulatory, not requiring legislation but having the force of law when implemented. Therefore, we urge President Obama to make speedy IRB reform a priority of his administration.

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