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by

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Building Trust between Institutional Review Boards and Researchers

Institutional Review Boards (IRBs), which play a central role in protecting the rights and welfare of research participants, have been criticized on multiple fronts.[1,2] The most common criticism arises from substantial empirical research showing wide and apparently random variation in how different IRBs adjudicate similar or identical research protocols.[3] Variation in IRB processes and decision making has been well-documented for the kinds of research that generalists commonly conduct, including health services research, survey research, medical education research, and quality improvement research. Such variation causes frustration among researchers and contributes to skepticism about IRBs' success in assuring the ethical conduct of research. In response to this and other criticisms, the Department of Health and Human Services has been working since 2011 to update the Common Rule, the primary federal regulation governing IRBs. Final changes to the Common Rule may be published later in 2016.

In this commentary, we propose that a central reason for ongoing frustration with IRBs stems from their failure to recognize their unavoidable policymaking role – a role that will persist regardless of anticipated changes to the Common Rule. We then make recommendations for increasing IRB transparency and accountability, which should reduce researchers' frustrations and foster greater trust in IRBs.

IRBs as research policymakers

The central challenge facing IRBs is that they must make decisions about diverse, complex, and novel research proposals about which the *Belmont Report*, the Common Rule, and other applicable regulations may give little or no specific guidance. Although

proposed updates to the Common Rule provide greater detail in some areas, many regulatory "gray zones" will remain after the final changes are adopted (See Table). For example, the proposed changes would not have prevented recent controversies about informed consent and "minimal risk" related to research on resident work hours.[4] The proposed requirement to use central IRBs for multicenter studies may improve efficiency, but it will not eliminate gray zones and may introduce new ethical challenges.

Therefore, to adjudicate protocols IRBs must act as *de facto* research policymakers for their institutions by interpreting federal regulations and creating policies to navigate gray zones. The Common Rule grants local IRBs wide discretion in these areas when reviewing protocols. When this discretion is not acknowledged (i.e., when IRBs present themselves as merely applying federal regulations), decisions are often driven by tacit, unwritten practices that are neither standardized nor subjected to adequate critical scrutiny. Variation in decisions and the attendant conflict and mistrust ensue.

Despite researchers' frustrations, IRB discretion is required for navigating gray zones and for ensuring the ethical conduct of research in a wide variety of settings. For example, local discretion can accommodate the needs and preferences of diverse communities and research institutions across the United States. Since institutional leaders and researchers may lack interest in or detailed knowledge about the ethical dimensions of their research, IRBs may need flexibility to make principled ethical judgments that protect the interests and welfare of research participants.

Responsible use of this broad discretion requires IRBs to first acknowledge it and then be willing to be held accountable for the manner in which they exercise it. Many IRBs deliberate in isolation and either lack access to or do not make use of sufficient

scientific, clinical, or ethical expertise relevant to the protocols they review.[5] Research shows that IRBs tend to adjudicate protocols in a disjointed, ad hoc manner rather than proactively developing and promulgating policies that they then apply to protocols that involve substantive ethical concerns in regulatory gray zones.[1,3] The following recommendations seek to alter this dynamic by making the research policymaking role of IRBs more explicit. If followed, they would increase transparency and accountability around IRB decisions. These recommendations are not meant as calls for additional regulation or for further changes to the Common Rule. Rather, they are recommendations for best practices that individual IRBs and research institutions can implement now within the current regulatory framework.

1. Explain IRB decisions in clear language

IRBs should be able to justify their decisions in terms that are clear to everyone affected by them: researchers, research participants, and the public. Using everyday language will promote greater focus on substantive ethical considerations and concerns rather than on the bureaucratic details and procedures that currently comprise the majority of IRB-mandated protocol changes.

2. Specify the sources justifying IRB decisions

IRBs should cite the specific sources that support their decisions, such as the Common Rule, written institutional policies, and/or IRB discretion. This practice, which many IRBs do not currently follow, will require IRBs to become more knowledgeable about federal regulations (and regulatory gray zones) and will clarify whether specific decisions emanate from federal regulations, IRB discretion, or some combination. Of course, determining whether something is mandated by the Common Rule requires some interpretation, but a good-faith effort to transparently separate decisions

prescribed by federal regulations from those based on IRB discretion would promote trust and encourage more productive discussions about disagreements.

3. Distinguish decisions to protect participants' welfare from decisions to advance institutional interests

IRBs are often sponsored by institutions that have additional interests other than the welfare of individual research participants. The Common Rule recognizes this and states that sponsoring institutions may prohibit IRB-approved protocols. To prevent IRBs from conflating protecting research participants with promoting sponsoring institutions' interests, IRBs should specify whether decisions are driven by concerns for research participants or for institutions.

For example, the Common Rule does not recognize racial subgroups as vulnerable, but an institution seeking to improve relations with a local Hispanic community may subject protocols focused on this group to additional scrutiny. While such practices are reasonable and permitted by the Common Rule, their justification stems from neither federal regulations nor concerns for individuals but from the institution's commitment to social justice. Such distinctions must be transparent to researchers so that they can better understand and respond to IRB decisions.

4. Specify whether and what kinds of empirical evidence are considered relevant to IRB decisions

The Common Rule requires IRBs to determine whether "risks to subjects are reasonable in relation to anticipated benefits . . ." when they adjudicate research protocols. In many cases, data from prior research can help IRB members to evaluate the likelihood and severity of risks associated with a specific protocol. IRBs should clearly explain whether they will solicit or weigh such evidence. Some IRBs may

consider peer-reviewed research to be relevant when evaluating potential risks. Other IRBs may only accept data derived from research involving local populations or their sponsoring institutions. Finally, some IRBs may not consider empirical data to be relevant at all for types of research that are proscribed by institutional policies. IRBs should be explicit about the extent to which they used empirical evidence, if at all, to guide their decisions.

5. Develop an appeals process.

Federal regulations neither suggest nor stipulate a process for reconsidering IRB decisions, but an organized appeals process will help to mitigate the inherent power imbalance between researchers and IRBs. Since neither the Common Rule nor the proposed changes allow for such a mechanism,[2] many researchers are understandably reluctant to question IRB decisions because they fear that doing so may adversely affect their future research. An appeals process that allows open discussion of disagreements could help to eliminate such fears. Implementing our first four recommendations would facilitate and simplify the appeals process, because everyone would know in advance the IRB's ethical concerns, the sources used to justify the decision, whether institutional concerns were considered, and the kinds of evidence relevant for resolving the disagreement. For example, a researcher is unlikely to appeal a decision if the IRB can demonstrate that the decision was prescribed by the Common Rule or written institutional policies.

Conclusion

Adopting these recommendations, which are consistent with the proposed changes to the Common Rule, will promote transparency and accountability around how IRBs exercise their discretion and shape local research policy. These

recommendations could also benefit research ethics committees outside the United States that may also function as local research policymakers. Individual institutions can encourage the IRBs they sponsor to implement these recommendations through training and changes to institutional research policy. Institutions can also make these recommendations a requirement for independent IRBs with which they do business. Widespread implementation of these recommendations will promote productive dialogue about research ethics within research institutions, and help to guard against the current prevailing focus on compliance. Implementation will also promote more consistent and defensible decisions from IRBs and greater trust between IRBs and researchers, both of which will strengthen public confidence in biomedical research.

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158 **Table. Examples of common regulatory "gray zones" that IRBs face.**

Topic	Example
Recruitment of research participants	When are researchers allowed to contact potential participants using "opt-out" rather than "opt-in" protocols?
Definition of "minimal risk"	When is physician (or patient) consent required for cluster-randomized clinical trials?
Equitable treatment for "vulnerable populations"	What additional protections should IRBs consider when reviewing research focused on economically disadvantaged patients?
Placebo use in clinical trials	Under what circumstances are placebos acceptable in Phase III trials for which FDA-approved treatments exist?
Regulation of quality improvement activities	When is IRB review and/or informed consent required for quality improvement research?

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