

UT COM Chattanooga

IRB Policies and Procedures

6/12/12

001: AUTHORITY, MEMBERSHIP AND PERMANENT POSITIONS

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**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
001: AUTHORITY, MEMBERSHIP AND PERMANENT POSITIONS**

I. PURPOSE

To document the authority, membership and permanent positions for the University of Tennessee College of Medicine Chattanooga/Erlanger Health System Institutional Review Board (UTCOMC/EHS IRB).

II. SCOPE

This SOP applies to the IRB Chair, Vice Chair, IRB administrator, and Board members.

Personnel Responsible

UTCOMC/EHS IRB administration and Board members

III. BACKGROUND

Any institution engaged in human subjects research that is supported or conducted by any department or agency of the federal government which has adopted the Federal Policy for the Protection of Human Subjects, known as the Common Rule (45CFR46, Subpart A), is required to establish a Federal Wide Assurance (FWA) with the Office for Human Research Protections (OHRP) of the Department of Health and Human Services (HHS). Under the terms of the Assurance, all of the institution's human subjects research activities, regardless of whether the research is subject to federal regulations, must be guided by the ethical principles in The Belmont Report and other appropriate ethical standards recognized by federal departments and agencies that have adopted the Common Rule. The three basic principles relevant to the protection of human subjects in biomedical and behavioral research as set forth in the Belmont Report are:

1. Respect for persons: recognition of the personal dignity and autonomy of individuals and special protection of those persons with diminished autonomy;
2. Beneficence: obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm; and
3. Justice: fairness in the distribution of research benefits and burdens.

In addition, all human subjects research undertaken by the institution that is conducted or supported by any federal agency which has adopted the Common Rule, must comply with the terms of the latter, as well as any additional human subjects regulations and policies of the federal agency which conducts or supports the research, and any other applicable federal, state, local, or institutional laws, regulations and policies. For research that is conducted or supported by HHS, the institution must comply with all subparts of the HHS regulations at 45 CFR 46, i.e., Subparts A, B, C, and D. For research that is not conducted or supported by any federal agency that has adopted the Common Rule, the University is voluntarily committed by the terms of its FWA to apply all aforementioned laws and regulations. The Common Rule includes the requirement that each institution to which the Rule applies must establish an Institutional Review Board (IRB) to oversee the application of relevant ethical principles and federal regulations in the conduct of human research.

A similar requirement for IRB review derives from regulations of the Food and Drug Administration (FDA). For all clinical investigations using articles regulated under sections 595(i), 507(d), and 520(g) of the Food, Drug and Cosmetic Act, FDA regulations require IRB review and the informed consent of subjects as specified at 21 CFR 50 and 56. In addition, under the revision of the investigational new drug (IND) application regulations of March 19, 1987, the same regulatory requirements apply to studies involving marketed drugs exempt from the IND requirements. Similar conditions are included in the investigational device (IDE) regulations addressing abbreviated requirements for certain categories of device investigations. Although FDA regulations for the protection of human subjects do not require institutions conducting FDA-regulated human research to have their own IRB, local IRB policy requires that any UTCOMC/EHS personnel conducting FDA-regulated studies must secure prior review and approval of the UTCOMC/EHS IRB.

The University of Tennessee Health Science Center (UTHSC) established the University of Tennessee Health Science Center Institutional Review Board in 1972. The UTCOMC/EHS IRB is linked to the UTHSC IRB by the Federal Wide Assurance. Erlanger Health Systems also holds a Federal Wide Assurance and has established the UTCOMC/EHS IRB as their primary review board. The IRB maintains a cooperative agreement with the National Cancer Institute (CIRB program). The IRB at its discretion may oversee research activities conducted by non-UTCOMC/EHS personnel who are not covered by any of the aforementioned agreements.

The UTCOMC/EHS IRB reports administratively to the UTCOMC Dean, the EHS President, and also to the UTHSC Assistant Vice Chancellor

for Research. The Board functions independently of all other administrative units and committees of the University. UTCOMC/EHS IRB is duly constituted and has written procedures in compliance with requirements defined in 45 CFR 46 and 21 CFR Parts 50 and 56. The mission of the UTCOMC/EHS IRB is to ensure that research is conducted according to the ethical principles of the Belmont Report and the Declaration of Helsinki, all federal regulations and international guidelines, institutional policies, and state laws, and to ensure that the rights and welfare of human subjects are adequately protected. The UTCOMC/EHS IRB has the authority to approve, require modifications in, and disapprove research protocols based on consideration of human subject protection, including the authority to:

1. Require IRB approval prior to the initiation of an investigation and recruitment of subjects.
2. Require progress reports from the investigators and oversee the conduct of the study;
3. Investigate complaints or reports of noncompliance or protocol deviations;
4. Suspend or terminate approval(s) or place restrictions on a study;
5. Evaluate the risk/benefit status of studies;
6. Ensure the adequacy of the informed consent process and informed consent documentation;
7. Manage potential conflicts of interest in the research; and
8. Ensure that the research has in place adequate mechanisms to protect human subjects, including the auditing of sites and monitoring of the informed consent process by using third party monitors.

Research that has been reviewed and approved by the UTCOMC/EHS IRB may be subject to review and disapproval by officials of EHS or UTCOMC, or any institution for which the UTCOMC/EHS IRB has agreed to serve as the IRB of record in accordance with an assurance filed with OHRP and a signed Memorandum of Understanding (MOU). However, those officials may not approve research that has been disapproved by the IRB.

In accordance with:

45 CFR 46.102(d), 107, 109; 21 CFR 56.107,109

OHRP Guidance on Written IRB Procedures, 1/15/07, located at <http://www.hhs.gov/ohrp/humansubjects/guidance/irbgd107.pdf>

OHRP Guidance on Protections for Human Subjects in the Human Genetic Mutant Cell Repository, Submission of Non-Identifiable Materials to the Repository (May 22, 1997)

Compliance with this policy also requires compliance with state and local laws and regulations that provide additional protections for human subjects.

DEFINITIONS

Case studies: The use of a single subject in research activity (n = 1) can constitute research that is subject to IRB review and approval when there is a clear intent before recruiting or interacting with the subject to use systematically collected data that would not ordinarily be collected in the course of daily life in reporting and publishing a case study. As a general rule, when a series of subject observations are compiled in such a way as to allow possible extrapolation or generalization of the results from the reported case, that activity constitutes research that must be reviewed by the IRB. Additionally, this type of activity must always be reviewed by the IRB when there is intent to publish or disseminate the data or findings. Even when a case study is not considered to be research subject to IRB review (because it is not intended to contribute to generalizable knowledge or otherwise does not meet the definition of research), these projects should follow the same guidelines for the protection of people's privacy, dignity, and welfare as if they required IRB review and approval.

Clinical investigation: Experiments using a test article on one or more human subjects that are regulated by the FDA or support applications for research or marketing permits for products regulated by the FDA. Products regulated include food and color additives, drugs for human use, medical devices for human use, biological products for human use, and electronic products.

1. Standard Diagnostic or Therapeutic Procedures: The distinction between research and treatment can become blurred in patient care settings, as well as in some educational and training settings.
 - a. An established and accepted diagnostic or therapeutic procedure that is performed only for the benefit of patient or student is generally not subject to IRB review.
 - b. However, collection of data about a series of such procedures or treatments for dissemination or generalization does constitute research that requires IRB review.
 - c. If patient care or assignment to intervention is altered for research purposes in any way, the activity must be submitted for IRB review.

- d. A diagnostic procedure for research purposes that is added to a standard treatment requires IRB review.
2. Innovative Procedures or Treatment: Innovations in diagnosis or therapy are not generally subject to IRB review IF they are applied to a patient for the sole purpose of aiding that individual. Such innovations are governed by the appropriate professional ethics (e.g., obtaining informed consent). IRB review is required when a “systematic investigation” of such innovations is considered. For example, if a physician plans to collect information about the innovation for scientific purposes or will repeat the innovation in other patients in order to compare it to standard treatment, the physician must receive prior IRB review.
3. Emergency Use of an Investigational Drug or Device: Federal regulations do not permit research activities to be started, even in an emergency, without prior IRB review and approval. When emergency medical care is initiated without prior IRB review and approval, the patient may not be considered a research subject. Nothing in FDA policies is intended to limit the authority of a physician to provide emergency medical care for patients who need such care. Rather, the use of information collected about that treatment for research purposes is prohibited. See UT COMC/EHS Policy 023 for additional information.

Human Cell or Tissue Repository: Collection, storage, and distribution of human tissue materials for research purposes. Repository activities involve the collectors of tissue samples, the repository storage and data management center and the recipient investigators. Human cell or tissue repositories do not qualify as involving human subjects research when material submitted to the repository satisfies both of the following conditions:

1. The material, in its entirety, was collected for purposes other than submission to the repository (i.e., the material was collected solely for clinical purposes, or for legitimate but unrelated research purposes, with no “extr” material collected for submission to the repository); and
2. The material is submitted to the repository without any identifiable private data or information (i.e., no codes or links of any sort may be maintained, either by the submitter or by the repository, that would permit access to identifiable private data or information about the living individual from whom the material was obtained).

Human subject: A living individual about whom an investigator (whether professional or student) conducting research obtains data

through intervention or interaction with an individual or identifiable private information.

1. Intervention includes both physical procedures by which data are gathered (e.g., venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.
2. Interaction includes communication or interpersonal contact between investigator and subject.
3. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (e.g., a medical record). Private information must be individually identifiable (i.e., the identity of the subject is or may readily be ascertained by the investigator or associated with the information) in order for obtaining the information to constitute research involving human subjects. This may include identifiable private information obtained from a primary subject regarding a third party.
4. NOTE: This definition does not apply to HIPAA regulations, which regulates PHI of the deceased.

Investigator-Initiated Research: Research conducted by a UTCOMC or EHS investigator who initiates and/or conducts a clinical investigation, alone or with others. It is the investigator's responsibility to inform the IRB of any unanticipated problems involving risks to subjects or adverse events that were serious or unanticipated and resulted in a change to the risk/benefit ratio, *even if the event occurred at a location for which the UTCOMC/EHS IRB is not the IRB of record.* It is also required that serious adverse events, even if they are expected and/or not related to study procedures, must be reported for studies occurring in investigator-initiated research (see Chapter 17 for additional information). The IRB recommends that an independent data safety monitor review all reportable adverse events and that these reports are forwarded to the IRB in a timely manner.

Research: Any systematic investigation (including research development, test and evaluation) designed to develop or contribute to generalizable knowledge.

Research Practicums/Research Methods Classes: Courses of study that are designed to train students and provide them with an opportunity to practice various research methods differ from research activities that would generally require IRB review in that the primary intent is for the student to become more knowledgeable

about the research process. Additionally, such projects typically do not lead to generalizable knowledge and are not undertaken with that goal in mind. Therefore, simulations of research using human subjects and course-assigned data are not deemed to be research that is subject to IRB review so long as the activity meets the following requirements:

1. The activities are designed for educational purposes only;
2. The data will not be generalized or published outside the classroom;
3. The data will not result in an article, master's thesis, doctoral dissertation, poster session, abstract, or other publication or presentation; and
4. The student volunteers or other participants are clearly informed that the activities are an instructional exercise and not actual research.

Although the IRB does not review such class projects, instructors are strongly encouraged to become fully familiar with each project to determine if there is a possibility that the student's proposed project may result in a formal presentation or publication, then he/she should recommend that the student submit the project for IRB review before beginning the study.

Student-Conducted Research: All activities that meet the definition of research with human subjects and that are conducted by students for a class project or for work toward a degree must be reviewed by the IRB (e.g., master's theses and doctoral dissertations that involve humans subjects and all projects that involve human subjects and for which findings may be published or otherwise disseminated).

IV. PROCEDURES

1. The IRB Chair

The Chair is a member of the IRB whose experience and expertise is documented in his/her CV. The Chair is appointed by the UTCOMC Dean with approval of the UTHSC Vice Chancellor for Research. The Chair will serve a term of three years and may serve successive terms at the discretion of the Dean of the UTCOMC and the UTHSC Vice Chancellor for Research. Removal of the Chair may be accomplished by resignation in writing or by written notification of termination of the appointment by the Vice Chancellor for Research. The Chair will perform functions including, but not limited to the following:

- a. Direct the proceedings of the full IRB. The position of Chair is a voting position.

- b. Establish and enforce the UTCOMC/EHS IRB policies and standards, as well as all applicable state and federal rules, regulations and statutes concerning human subject protection. As a primary representative of IRB decisions, the Chair has authority over all IRB policies and procedures.
- c. Represent the IRB in discussions with other segments of the organization.
- d. Review all protocols presented to the Board and communicate as necessary with all IRB subcommittees, consultants, auditors, and other reviewers so that all IRB issues are identified and resolved.
- e. Review and make decisions about responses to administrative provisos for IRB approval.
- f. Conduct review of proposals submitted for expedited review or exempt status. This task may be shared with other senior members of the IRB as delegated by the Chair, depending on expertise.
- g. Review all reports of adverse events, safety reports, data safety monitoring board reports, MedWatch reports, protocol deviation reports, continuing review reports, reports of unanticipated problems or unexpected risks to subjects and/or others, and reports of complaints or noncompliance.
- h. Enforce corrective actions for violations.
- i. Exercise oversight authority for all professional and administrative functions of the IRB.
- J. Distribute investigators' applications and review packets.
- k. Assist the IRB in drafting letters and other communications from the IRB to researchers, sponsors and regulatory authorities or agencies concerning IRB decisions. The Chair will review and sign correspondence in a timely manner.
- l. Interact with investigators, coordinators, sponsors, institutional officials, subjects, and auditors regarding ethical questions, questions of IRB policy, IRB oversight, and human subject protections.
- m. Assist in preparing any reports and recommendations as may be mandated or required.
- n. Report to the IRB, sponsor, as required for the following events:
 - i. Any unanticipated problems involving risks to subjects or others;
 - ii. Any serious or continued noncompliance with the regulations or protocol requirements;

- iii. Any serious or continued noncompliance with the policies of the IRB; and
 - iv. Any suspensions or terminations of IRB approval.
- o. Direct audits of clinical sites for compliance with IRB policies and procedures, as well as other applicable laws and regulations.

2. **The IRB Vice Chair**

The Vice Chair is a member of the IRB whose experience and expertise is documented in his/her CV. The Vice Chair is selected from the membership of the IRB. The Vice Chair is appointed on the advice of the Chair by the UTCOMC Dean with approval by the UTHSC Vice Chancellor for Research. The Vice Chair will perform functions including, but not limited to the following:

- a. Execute all duties and responsibilities of the Chair in the latter's absence; and
- b. Assist the Chair in the performance of his/her duties.

3. **The IRB Administrator (and staff)**

The IRB Administrator is expected to maintain files in a manner that represents a complete history of all IRB actions related to review and approval of a protocol, including continuing reviews, amendments, and adverse event reports for at least three (3) years. For all applications that are approved and research initiated, the IRB Office must retain all records regarding that research for at least three years after completion of the research.

All records must be accessible for inspection and copying by authorized representatives of the sponsoring department or agency at reasonable times and in a reasonable manner.

The IRB Administrator will perform functions including, but not limited to the following:

- a. Develop and implement IRB policy;
- b. Develop standard operating procedures (SOPs) and update current SOPs (at least annually), and direct training of all staff, IRB members, consultants and auditors regarding applicable laws and regulations for the protection of human subjects;
- c. Develop and implement IRB policies and procedures regarding HIPAA regulations, and train all IRB staff, members, and consultants on these requirements;

- d. Develop, implement, and update as necessary an orientation program for all new staff and IRB members;
- e. Create and maintain training files for all IRB staff, members and consultants;
- f. Under the direction of the Chair, seek out appropriate new members, consultants, ad hoc members, staff members and auditors;
- g. Develop, update and oversee the IRB investigator-training program on the conduct of human research according to ethical and regulatory requirements;
- h. Advise the university and EHS administration, departments, investigators, and compliance officials on IRB policies and procedures;
- i. Review all submission packets for completeness and follow up on any issues needing clarification prior to the IRB meeting and/or review of such submissions;
- j. Serve as a contact person for communications regarding IRB deliberations, review, and actions; oversee preparation and signatures of correspondence from IRB regarding these deliberations, review, and actions.
- k. Create, maintain, and archive comprehensive IRB minutes and documents concerning IRB functions and meetings.
- l. Assist the chair to distribute investigators' applications and review packets;
- m. Triage research between IRB review categories along with the Chair (full board review, expedited review, exempt, HIPAA waivers);
- n. Serve as contact person and liaison for audits from sponsors, OHRP or FDA; develop, update and implement procedures for managing and responding to these types of audits;
- o. Assist the Chair in reviewing serious adverse events, safety alerts, MedWatch, protocol deviations, unexpected problems or unanticipated risks to subjects or others, injury to subjects, complaints or reports of noncompliance; coordinate appropriate follow-up as needed by the IRB or Research Compliance Office; initiate and coordinate implementation of any policies and/or procedures related to such reports;
- p. Implement, track, review and coordinate IRB communication regarding continuing review;
- q. Monitor and manage conflict of interest reports per IRB policies and procedures;
- r. Implement, manage, and communicate reports of any IRB subcommittees and the Scientific Review Committee;

- s. Coordinate IRB meetings, including preparing of the agenda, assignment of review responsibilities, distribution of materials, and notification of relevant parties regarding time and place;
- t. Create, update, and maintain the IRB website;
- u. Review submissions and prepare written correspondence with investigators, sponsors, or the FDA concerning any submissions for emergency use or compassionate use;
- v. Invoice, receive and manage all IRB accounts receivable and accounts payable;
- w. Maintain and update IRB information concerning federal regulations, guidelines, information sheets, applicable state and local laws and institutional policies regarding human subject research;
- x. Assume responsibility for the files of the IRB, whether electronic or paper, including archiving, tracking, storage, retrieval, QA and security;
- y. Coordinate, prepare appropriate paperwork, and maintain any correspondence concerning applications for and updates of the IRB Assurance(s).

4. The IRB Membership

UTCOCM/EHS IRB membership is a privilege and responsibility granted by invitation to scientific and non-scientific members of the academic and local community. Members will be sufficiently qualified through their experience, expertise and diversity, including consideration of race, gender, cultural attitudes and sensitivity to community attitudes, to ascertain the acceptability of proposed research in terms of institutional commitments, federal regulations, applicable law, and standards of professional conduct and to promote respect for the Board's advice and counsel in safeguarding the rights and welfare of human subjects.

Board functions shall include (but are not limited to):

- a. UTCOCM/EHS IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The maximum number of board members is thirty. Alternate members are allowed to maintain a working quorum of the IRB.
- b. Insofar as the UTCOCM/EHS IRB reviews research that involves vulnerable categories of subjects, such as children, prisoners, pregnant women, physically or mentally disabled persons, membership will include one

- or more individuals who are knowledgeable and experienced in working with those vulnerable subjects.
- c. The UTCOMC/EHS IRB will not consist entirely of members of one profession.
 - d. UTCOMC/EHS IRB will include at least one member whose primary concerns are in the scientific area (examples: physicians, nurses, pharmacists, dentists); at least one member whose primary concerns are in nonscientific areas (examples: lawyers, clergy, administrators, ethicists); and at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution (sometimes called a community member).
 - e. All prospective applicants will be evaluated for potential membership (full or alternate) or as an ad hoc consultant (or non-voting member) based on the following:
 - i. Evidence of education and training (as documented by CV);
 - ii. Community service and/or length of residence in the community;
 - iii. Specific needs of the IRB; and
 - iv. Willingness and time to serve.
 - f. Membership may include, but is not limited to:
 - i. Ethicists
 - ii. Members of the legal profession
 - iii. Clergy
 - iv. Members of the medical and other health care professions
 - v. Other scientists or non-scientists to provide the necessary expertise to evaluate the research proposals and the informed consent process
 - vi. Lay persons representing the values and attitudes of the community from which research subjects are drawn
 - vii. Representatives of special populations, such as a prisoner representative
 - g. All stipulations for full membership apply to the Chair and Vice Chair.
 - h. All members will sign a confidentiality agreement that will be maintained in the IRB file.
 - g. Prospective applicants for Board members submit supporting documents, including a CV or resume and a copy of any professional license (if applicable to their application) to the IRB Administrator.

- h. All new members will be required to complete the CITI Tutorial for IRBs.
- i. IRB members are appointed by the UTCOMC Dean with approval by the Associate Vice Chancellor for Research for a three-year term and may be reappointed for successive terms at the discretion of the Dean and Vice Chancellor.
- j. Prospective applications for Board membership submit to the IRB Administrator supporting documents, including a current CV or resume and a copy of any professional license (if applicable to their application).
- k. Upon notification of a member's appointment, the IRB Administrator will prepare a letter of appointment for the member and provide it to the Associate Vice Chancellor for Research for signature.
- l. Once signed, the IRB administrator will forward the original letter to the member and maintain a copy in the IRB records.
- m. The new member's name will be added to the IRB Roster. A copy of the new roster will be sent to OHRP for filing.
- n. The IRB administrator will send a copy of the IRB policies and procedures and other current educational documents to the new member.

5. Alternate Members

Each IRB member may have an alternate member appointed to serve in the absence of the member. Alternate members may serve as an alternate for more than one member only if the alternate has comparable experience, expertise, background, professional competence and knowledge as the primary IRB members whom the alternate would replace. Alternate members are appointed in accordance with guidelines in Section 4 above. Alternate members may attend any IRB meeting, but may not vote if the principal IRB member is present.

6. Ad Hoc/Consultant Members

When reviewing research that involves children, prisoners, pregnant women, physically or mentally disabled persons, or other category of subjects deemed vulnerable by the IRB (eg, students, elderly, employees of the site or institution, members of specific culturally groups or minorities), consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in

working with these subjects, when such individuals are not otherwise represented on the Board. In addition, the membership may invite individuals with competence in special areas to serve on an ad hoc basis to assist in the review of studies requiring expertise beyond that of the members. Ad hoc members are appointed in accordance with guidelines in Section 4 above. The ad hoc member will attend the IRB meetings to participate in the discussion of proposed research but at no time will be allowed to vote. The ad hoc member may provide the IRB comments in writing prior to the meeting.

7. Non-Voting Members

UTCOMC/EHS IRB may, at its discretion, call upon individuals with competence in special areas or knowledge of institutional policies, community attitudes and state laws pertaining to research, to assist in the review of issues requiring expertise beyond or in addition to that available in the IRB membership. The purpose of non-voting members is to advise the IRB on specific questions and at no time will be allowed to vote.

8. Membership Roster

A roster of IRB members and alternates is created and maintained by the IRB Administrator. The roster will identify members by:

- a. Name
- b. Earned degrees
- c. Experience, qualifications, specialty (board certification, licenses, IRB certification)
- d. Designation as principal, alternate member, ad hoc, or non-voting member
- e. Scientific or non-scientific designation
- f. Employment or relationship to IRB or other members
- g. Hospital or institutional affiliation

The membership roster is reviewed annually by the IRB administrator and Chair to assure appropriate membership and diversity as outlined in 21 CFR 56 and 45 CFR 46. The checklist for IRB membership is used for the documentation of this review and assurance.

9. Attendance

Members are expected to attend all scheduled meetings in order to maintain their appointment to the Board. The IRB Administrator will maintain a log of attendance with

cumulative attendance on a calendar year basis for review by the IRB Chair.

The Chair may ask for the resignation of the member if deemed appropriate.

10. Removal of Members and Vacancies

A member, alternate, ad hoc or non-voting member may be removed with or without cause from the IRB by the action of the Vice Chancellor for Research and the UTCOMC Dean on the recommendation of the Chair. Six consecutive absences or a pattern of non-attendance are grounds for dismissal. The Chair or Vice Chair may resign with a one-month notice. A member may resign from the IRB by submitting a letter or resignation to the Chair.

Vacancies shall be filled by the appointment process described in Section 4 above.

11. Quorum

The UTCOMC/EHS will conduct business only when a quorum of members is present. The quorum is a simple majority of members, but must include one non-scientific and one non-affiliated or "community" member (this may be the same person). The IRB Administrator will note any loss of quorum in the minutes.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
002: MEMBER EDUCATION**

I. PURPOSE

To describe educational programs and materials available to members of the UTCOMC/EHS IRB regarding protection for the rights and welfare of human subjects.

II. SCOPE

This SOP applies to the IRB Chair, IRB administrator and IRB members.

Personnel Responsible:

IRB administrator, IRB Chair, and IRB members

III. BACKGROUND

In order to maximize the effectiveness of IRB members in protecting the rights and welfare of human subjects, it is crucial that Board members are knowledgeable regarding federal regulations for the protection of human subjects, ethical codes on the conduct of research with human subjects, and local IRB policies and procedures.

This goal is accomplished through a variety of means. Newly appointed Board members participate in an orientation session intended to introduce them to federal rules for the protection of human subjects, major codes of research ethics, and local IRB policies and procedures. All members are required to complete the CITI online tutorial for IRB members. Relevant educational materials and programs regarding current ethical and regulatory issues in the protection of human subjects are provided as continuing education for Board members. IRB members are encouraged to attend local and national seminars related to institutional review boards and human subject protection. In addition, the IRB subscribes to journals and other publications of relevance to the function and activities of IRBs. Finally the IRB encourages membership in pertinent professional organizations, such as the Association of Clinical Research Professionals (ACRP), Public Responsibility in Medicine and Research (PRIM&R), and the Applied Research Ethics National Association (ARENA).

IV. PROCEDURES

1. Orientation of new members
 - a. The IRB Chair and administrator are responsible for establishing and modifying the IRB orientation program as updates are required due to changes in regulations, guidance documents or local policy and procedures.
 - b. New members will be scheduled for orientation once they are appointed and have signed a confidentiality agreement.
 - c. Orientation will include review of the following items and their provision to new members:
 - i. IRB standard operating procedures and other relevant administrative documents;
 - ii. Application forms and reviewer forms utilized by the IRB in assessing research applications
 - iii. Major ethical codes and guidelines regarding protection for the rights and welfare of human subjects, including the Nuremberg Code, the Declaration of Helsinki, and the Belmont Report; and
 - iv. Federal regulations on the protection of human subjects at 45 CFR 46, 21 CFR50 and 21 CFR 56.
 - d. Completion of the online training CITI course in the protection of human subjects (<http://www.utcomchatt.org/subpage.php?pageId=1005>) is required. A copy of the training certificate of completion will be kept in the training files.
 - e. Orientation may be completed on an individual or group basis.
2. Continuing Education
 - a. Any member of the IRB may submit educational materials, articles and notice of seminars and educational events to the IRB administrator for distribution to all members.
 - b. Educational materials will be made available to the IRB as deemed appropriate. During the IRB meeting, educational material may be discussed.
3. Documentation

Documentation of members' completion of orientation and online training will be maintained in the membership files by the IRB administrator.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
003: PROCEDURES FOR FULL BOARD REVIEW**

I. PURPOSE

To outline the required elements of Institutional Review Board (IRB) procedures concerning full board review of studies submitted to the University of Tennessee College of Medicine Chattanooga/Erlanger Health System Institutional Review Board (UTCOMC/EHS IRB) under Department of Health and Human Services (HHS) regulations for the protection of human subjects at 45 CFR 46 and Food and Drug Administration (FDA) regulations at 21 CFR 50 and 56.

II. SCOPE

This SOP applies to all IRB Chair, administrative staff and Board members.

Personnel Responsible:

IRB members

III. BACKGROUND

The UTCOMC/EHS IRB has the authority to perform the following functions under federal regulations for the protection of human subjects:

1. Conduct initial and continuing review of any research activities involving use of a drug or device, or other medical, behavioral, educational interventions involving human subjects;
2. Report findings and actions to the investigator and sponsor, as applicable;
3. Determine which studies need more than annual review;
4. Determine which studies need verification from sources other than the investigator that no material changes have occurred since previous IRB review;
5. Insure prompt reporting to the IRB of changes in research activities;
6. Insure that changes in previously approved human subject research are not initiated without IRB review and approval, except when necessary to eliminate apparent immediate hazards to the subject;

7. Insure prompt reporting to the IRB of unanticipated problems involving risks to subjects or others, or any serious or continuing noncompliance with federal regulations or the requires or determinations of the IRB;
8. Review and ensure the adequacy of the informed consent document and process;
9. Review and approve both HIPAA authorization language incorporated into the informed consent document and requests for waiver of the HIPAA authorization requirements;
10. Suspend or terminate research or revoke approval of any study under its review;

Review of research occurs at convened meetings at which a majority of the voting members are present, including at least one member whose concerns are non-scientific and one member of the community.

Approval of research by the UTCOMC/EHS IRB is not in itself a commitment or approval by the institution(s) where the research involves the use of the institution's facilities or personnel.

In accordance with:

45 CFR 46.103(b)(4) and (5); 45 CFR 46.108(a); 45 CFR 46.111; 21 CFR 50, 56

OHRP Common Findings and Guidance; OHRP Guidelines for Formulating Written IRB Policies and Procedures; OHRP Guidance for Continuing Review.

IV. PROCEDURES

1. Submissions
 - a. Submissions to the UTCOMC/EHS IRB should be sent to:

UTCOMC/EHS IRB
960 Whitehall Building, Suite 100
Chattanooga, TN 37403
Phone: 423-778-3818
Fax: 423-778-4170
Email: Stacey.Hendricks@erlangier.org

- b. The IRB Chair or designee will determine whether submissions qualify for full Board review, expedited review, or exempt status. The full Board will be required to review all studies that involve more than minimal risk or do not otherwise qualify for expedited review or exempt status.

- c. For new studies requiring full Board review, the principal investigator will submit the following documents by the deadline listed on the IRB website (generally 21 days prior to the scheduled IRB meeting) available at [Institutional Review Board Overview - University of Tennessee: College of Medicine Chattanooga](#).
- i. A completed Initial Approval Form ([Form A](#)) with a signature page and conflict of interest statement;
 - ii. Full investigator's or sponsor's protocol;
 - iii. Proposed informed consent document(s) and/or script as appropriate;
 - iv. Copies of surveys, questionnaires, or videotapes as appropriate;
 - v. Copies of letters of assurance or cooperation with research sites;
 - vi. Relevant grant applications;
 - vii. Investigator's brochure (if one exists); and
 - viii. Advertising intended to be seen or heard by potential subjects, including email solicitations.
- d. Continuing review of research is necessary to determine whether the risk/benefit ratio has changed, whether there are unanticipated findings involving risks to subjects, and whether any new information should be provided to subjects. Review must occur not less than once per year. All research (unless determined by the IRB to qualify as exempt) must be periodically reviewed. For annual continuing review or revisions of previously approved studies requiring full board review, the principal investigator will submit the following documents:
- i. A completed Continuing Review Form ([Form D](#));
 - ii. A revised sponsor protocol when applicable;
 - iii. Revised informed consent;
 - iv. Sponsor's monitor report or data safety monitoring board reports when applicable.
- e. Revisions will qualify for expedited review only if there are minor changes, corrections, or clarifications, such as changes in study staff, study procedures or the consent disclosure. If the principal investigator is being changed a letter from the new principal investigator must be included stating that he/she is aware of the change and is assuming responsibility for the study.

For expedited revisions, the following documents are required:

- i. A completed Continuing Review Form ([Form D](#));
- ii. Revised sponsor protocol
- iii. Revised informed consent document

2. Document Distribution

IRB binders are delivered to Board members at least five days prior to the IRB meeting. This is the responsibility of the IRB administrator or designee. The following materials will be sent to the Board members:

- a. Initial review applications
 - i. A completed Initial Approval Form ([Form A](#)) with a signature page and conflict of interest statement;
 - ii. Full investigator's or sponsor's protocol;
 - iii. Proposed informed consent document(s) and/or script as appropriate;
 - iv. Copies of surveys, questionnaires, or videotapes as appropriate;
 - v. Copies of letters of assurance or cooperation with research sites;
 - vi. Relevant grant applications;
 - vii. Investigator's brochure (if one exists); and
 - viii. Advertising intended to be seen or heard by potential subjects, including email solicitations.
- b. Continuing review applications

The following materials will be sent to the Board members:

- i. A completed Continuing Review Form ([Form D](#));
- ii. A revised sponsor protocol when applicable;
- iii. Revised informed consent;
- iv. Sponsor's monitor report or data safety monitoring board reports when applicable.

If research is closed to accrual of new subjects, the protocol will be reviewed until such time that:

- i. Initial analysis of the data has concluded that no new information needs to be provided to enrolled subjects; and
 - ii. There is no need to re-contact enrolled subjects to obtain additional research information.
- c. Revision applications

The following materials will be sent to the Board members for review:

- i. A completed Continuing Review Form ([Form D](#))
- ii. A revised protocol highlighting changes
- iii. Revised consent form if applicable
- iv. Sponsor correspondence (if applicable)

3. Review process

- a. Full Board review will be required of all new studies that involve more than minimal risk to human subjects or do not otherwise qualify for expedited review or exempt status.
- b. All IRB members will review the materials distributed as listed above.
- c. At the full Board meeting, following a synopsis of the study and response to questions by the principal investigator or (if not available) a designee, the Board members will discuss their assessment of any significant issues and their recommendations. Any additional presenters/guests beyond key personnel require prior approval by the IRB.
- d. For revisions of studies requiring full Board review, following a synopsis of the study and response to questions by the principal investigator or (if not available) a designee, the Board members will discuss their assessments of any significant issues and their recommendations.
- e. Adverse event reports may be reviewed by the full Board, the Chair or designee. All adverse events will be placed on the Activity Report and distributed to the all Board members. Discussion of adverse events will occur if there are reasonable grounds for revision of the risk/benefit assessment or informed consent disclosure, or if review is requested by a Board member.
- f. All members voting on a protocol must be free of conflicts of interest with respect to the protocol, institution, or sponsor involved, and any member having

a conflict of interest shall disqualify himself/herself in a given review. IRB members who are investigators, co-investigators or have a conflict of interest will leave the meeting at the time indicated by the Chair for discussion, deliberation and voting.

- g. Action items will be reviewed first to ensure that potential loss of quorum does not delay any agenda items requiring review and vote.
- h. Review of unanticipated problems (other than adverse events) involving risks to subjects or others, or serious or continuing noncompliance will be first reviewed by the Chair (upon receipt of information) and will then be discussed at the next full Board meeting. Any discussion/action decided upon will be documented in the minutes for that meeting and communicated to the investigator/sponsor/FDA or other regulatory authority as required by federal regulations in writing within 48 hours.
- i. The expedited review process is an alternative to a convened meeting and may be used for those activities listed in the federal regulations as eligible for expedited review.
- j. Decisions are made independently for each research proposal submitted.
- k. The following actions, determined by majority vote of the quorum present, may be taken on any application:
 - Approval without provisos;
 - Approval pending satisfaction of administrative provisos;
 - Deferral of approval pending satisfaction of provisos requiring further review by the full Board; or
 - Disapproval.

Approval pending satisfaction of administrative provisos will only occur when the convened IRB stipulates specific revisions requiring simple concurrence by the investigator; the Chair (or designee) may subsequently approve the revised research protocol, consent form, or other materials on behalf of the IRB under an administrative review procedure. Deferral of approval pending satisfaction of full Board provisos will apply to applications for which the IRB does not only stipulate specific revisions, but which require the investigator to address substantive issues raised in the IRB deliberations. In the latter case, subsequent review and approval of the full Board is required.

- l. Should a quorum fail during a meeting, the IRB may not take further action until a quorum is restored. Loss of

quorum can occur due to early departure of members, absence of a nonscientist, or loss of eligibility to vote of members with conflicts of interest.

- m. Telephonic participation: Whenever possible, IRB meetings should take place with all participating IRB members physically present. However, circumstances sometimes warrant conducting IRB meetings via telephone conference call. Official Board actions may be taken at a meeting which members participate via telephone, providing that each IRB member:
 - i. Has received all pertinent material prior to the meeting; and
 - ii. Can actively and equally participate in the discussion of all protocols (i.e., each member can hear and be heard by all other participating members).

Minutes of such meetings must clearly document that these two conditions have been satisfied in addition to the usual regulatory requirements.

- 4. Minutes
Minutes will be completed for each meeting.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
004: CRITERIA FOR IRB APPROVAL OF NEW RESEARCH
APPLICATIONS**

I. PURPOSE

To outline the criteria for approval of studies reviewed by the UTCOMC/EHS IRB

II. SCOPE

This SOP applies to all IRB administrator and Board members

Personnel Responsible:

IRB administrator and Board members

III. BACKGROUND

General criteria for IRB review and approval of research are stipulated in the Common Rule at 45 CFR 46.111. Identical criteria for IRB review and approval of FDA-regulated research are provided at 21 CFR 56.111. Numerous additional guidance documents for interpreting and applying these criteria are provided by the Office for Human Research Protection of the Department of Health and Human Services, the Food and Drug Administration, and other federal departments and agencies involved in conducting or supporting research with human subjects. These guidance documents are supplemented by various codes of research ethics, such as the Declaration of Helsinki of the World Medical Association and the guidelines for biomedical research involving human subjects of the Council for International Organizations of Medical Sciences.

In accordance with:

45 CFR 46.111; 21 CFR 56.111; OHRP Guidance on Written IRB Procedures (1/15/07)

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Criteria reviewed by IRB

- a. Risks to subjects are minimized.
 - i. The study uses procedures that are consistent with sound research design. This includes a review of the scientific validity of the protocol and scientific rationale (including results of previous animal and human studies) for conducting the study.
 - ii. The investigators are competent in the area being studied.
 - iii. When appropriate, the study uses procedures already being performed on the subjects for diagnostic or treatment purposes.
 - iv. Appropriate screening and monitoring procedures are utilized to protect the subjects from harm.
- b. Risk(s) to subjects are reasonable in relation to anticipated benefits.
 - i. The risk-benefit profile of any treatment intervention evaluated in the study is not known to be significantly more or less favorable than any available alternative treatment.
 - ii. Non-therapeutic interventions used in the study do not involve more than minimal risk or a modest increase over minimal risk.
 - iii. The value of the knowledge to be gained in the study justifies any increment of risk to subjects resulting from participation in the research.
 - iv. The IRB shall not consider possible long-range effects of applying knowledge gained in the research as among those research risks that fall within its responsibility.
- c. Selection of subjects is equitable.
 - i. Recruitment will be open to all prospective subjects who may benefit from the study participation without regard to sex, religion, race or ethnicity.
 - ii. Vulnerable populations such as children, fetuses, neonates, pregnant women and prisoners, as well as economically or educationally disadvantaged persons will not be used without scientific justification in research that does not offer the prospect of direct benefit to subjects.
- d. Informed consent is adequate.
 - i. The consent form contains the required elements of information as specified in federal regulations.
 - ii. The information that is given to the subject or the legally authorized representative will consider the

- study population to gauge the readability of the consent disclosure.
- iii. The language of the informed consent should be one in which the subject or the subject's legally authorized representative is fluent.
 - iv. A consent interview will be conducted with prospective subjects which involves presentation of the main elements of information required for informed consent.
 - v. When the subject cannot read the consent form, an impartial third party should witness the entire consent process and sign the consent document.
 - vi. The consent of the subject or the legally authorized representative will be appropriately documented as specified in IRB SOP #6.
- e. Where appropriate, the research plan makes provision for monitoring the data to insure safety of subjects.
- i. The IRB will determine that the plan for monitoring the study data and subject safety is appropriate to the degree of risk associated with participation.
 - ii. The IRB will determine if a DSMB is required for the study. If so, the IRB will require the investigator or sponsor to submit DSMB reports for the study to the IRB in a timely fashion.
 - iii. The IRB may ask the investigator for copies of monitoring reports for the investigative sites.
 - iv. The IRB may perform site audits
- f. Where appropriate, there are adequate provisions to protect the privacy of subjects and maintain confidentiality of data.
- i. Procedures for protecting the confidentiality of subject data, including the use of coded records, are instituted.
 - ii. Procedures, if any, for including research data in the medical record of subjects are specified.
 - iii. Investigators will observe the rights of subjects with regard to the use of their protected health information as required under the HIPAA regulations.
 - iv. Subjects will not be individually identified in any presentations or publications based on the research.
- g. Appropriate safeguards are included in the study to protect the rights and welfare of vulnerable subjects. Additional protections will be considered for protocols involving the enrollment of:
- i. Pregnant women, fetuses, and neonates;

- ii. Prisoners;
- iii. Children;
- iv. Other subjects who are at increased risk of harm or have an impaired ability to decide about research participation

2. Appeal of IRB decisions

- a. The decision of the UTCOMC/EHS IRB to approve a research protocol may be appealed by the investigator. However, the investigator does not have the authority to overrule the IRB's disapproval or modification of a research protocol.
- b. Institutions in which studies approved by the IRB will be conducted have the right to prohibit, suspend, or terminate such studies, or to require alteration of such studies as a condition of their performance at the institution. Any alterations in such studies required by the institution must also be approved by the IRB prior to their implementation.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
005: INFORMED CONSENT**

I. PURPOSE

To outline the procedures for UTCOMC/EHS IRB concerning informed consent and its documentation.

II. SCOPE

This SOP applies to the IRB administrator, IRB members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members

III. BACKGROUND

The fundamental purpose of IRB review and approval of the consent process and document is to protect the rights and welfare of human subjects. Investigators may not generally involve a human subject in clinical research without the legally effective informed consent of the subject or the subject's legally authorized representative. The informed consent disclosure must be presented in language understandable to the subject, with all required elements of information as specified in the regulations and local IRB policy. Investigators may seek consent only under circumstances that provide the subject sufficient opportunity to consider whether to participate in the study and that minimize the possibility of coercion or undue influence. In addition, no consent disclosure may contain exculpatory language through which the subject of the subject's legally authorized representative waives or appears to waive any of their legal rights, or releases or appears to release the investigator, sponsor, institution or its agents from liability for negligence. The informed consent document is the written summary of the information provided to the subject in the informed consent interview, and the subject's signature on the consent form documents the prior informed and voluntary agreement of the subject to participate in the study.

UTCOMC/EHS IRB is responsible for ensuring that procedures are in place to appropriately provide the subject or legally authorized representative with the elements of information needed by a reasonable person to make a decision about research participation.

UTCOMC/EHS IRB also has the authority to audit investigators and/or observe the informed consent process to assure that consent is obtained and documented, and that records are maintained, in accordance with this standard operating procedure.

This policy is not intended to limit the authority of a physician to provide emergency medical care or to preempt any applicable local, state or federal laws which require additional information to be disclosed in order for informed consent to be legally effective.

In accordance with:

45 CFR 46.109; 45 CFR 46.111; 45 CFR 46.116; 21 CFR 50.20, 50.25 and 50.27; 21 CFR 56.109 and 56.111

FDA IRB Information Sheets: Guide to Informed Consent, 1998 located at [Guide to Informed Consent](#)

FDA IRB Information Sheets: Frequently Asked Questions on Informed Consent Process and Informed Consent Document Content [Information Sheet Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors](#)

OHRP Guidance on Informed Consent located at [OHRP Policy Guidance \(by topics\)](#)

OHRP FAQs on Informed Consent located at [Human Research Questions & Answers \(OHRP\)](#)

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURE

1. General requirements:
General requirements for adequate informed consent and documentation of consent include the following:
 - a. No investigator may involve a human being as a subject in research covered by this policy unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative. An investigator shall seek such consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The

information that is given to the subject or the representative shall be in language understandable to the subject or the representative. No informed consent disclosure, whether oral or written, may include any exculpatory language through which the subject or the representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the investigator, the sponsor, the institution or its agents from liability for negligence.

- b. UTCOMC/EHS IRB requires the investigator to outline the process for obtaining consent and securing written documentation of consent in the informed consent section of the **Initial Approval Application, Form A**. This section must also specify who has the authority to obtain informed consent. If the study will involve accrual of subjects for whom consent must be secured from the legally authorized representative, this plan must be explained and justified in this section as well.
- c. The process of obtaining informed consent must normally involve an informed consent interview conducted in person. Inviting the subject to read and sign the consent form is not sufficient for securing informed consent. Any alteration of this process must be requested as an alteration of informed consent under 45 CFR 46.116(d), with a justification that establishes that the conditions for approving an alteration under the regulations are satisfied.
- d. Investigators are responsible for assessing the subject's capacity to consent.
- e. When prospective subjects lack adequate decision-making capacity, investigators may not involve them in clinical research without the legally effective informed consent of the subject's legally authorized representative (LAR). Identification of the LAR for a subject incapable of making an autonomous decision is governed by state law. The LAR must:
 - i. Be an adult who has exhibited special care and concern for the for the subject;
 - ii. Be familiar with the subject's personal values;
 - iii. Be reasonably available; and
 - iv. Be willing to serve.

No person who is identified in a protective order or other court order that directs that person to avoid contact with the subject shall be eligible to serve as the subject's LAR. Identification of an LAR should normally be made using the following order of descending preference:

- i. Conservator;
 - ii. Guardian;
 - iii. Attorney-in-fact;
 - iv. Subject's spouse, unless legally separated;
 - v. Subject's adult child;
 - vi. Subject's parent;
 - vii. Subject's adult sibling;
 - viii. Any other adult relative of the subject; or
 - ix. Any other adult who is familiar with the patient's personal values, who is reasonably available, and who is willing to serve as LAR.
- f. Securing informed consent by telephone is generally not allowed. It is acceptable to send the informed consent document to the subject or LAR by facsimile (fax) and conduct the consent interview over the telephone when the subject or LAR can read the consent form as it is discussed. If the consent form is signed, it may be sent back to the investigative site by fax. The consent with the original signatures must be mailed or brought to the investigative site at the earliest opportunity. Any alteration of this process for securing consent by telephone must be requested as an alteration of informed consent under 45 CFR 46.116(d), with a justification that establishes that the conditions for approving an alteration under the regulations are satisfied.
- g. The UTCOMC/EHS IRB may approve an alteration or waiver of informed consent under 45 CFR 46.116(d) provided that the IRB finds and documents the following conditions. Satisfaction of these conditions must be established by the principal investigator in the informed consent section of the Initial Approval, Form A:
- i. The research involves no more than minimal risk to the subjects;
 - ii. The waiver or alteration will not adversely affect the rights and welfare of the subjects;
 - iii. The research could not practicably be carried out without the waiver; and
 - iv. Whenever appropriate, the subjects will be provided with additional pertinent information after participation.
- h. The UTCOMC/EHS IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either:
- i. That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will

- be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern; or
- ii. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

In cases in which the requirement for written documentation of consent is waived, the IRB may require the investigator to provide subjects with a written statement regarding the research.

- i. UTCOMC/EHS IRB requires the following signatures to be obtained and dates by the signatory on the informed consent document:
 - i. Subject or LAR (as described in (1e) of this section);
 - ii. A witness who attests to the fact that the person who signs the consent document as the subject or LAR is the person represented by the affixed signature. A witness should be someone not involved with the clinical study (impartial witness);
 - iii. The person obtaining consent who is informed and knowledgeable about the study and study requirements, and authorized in the approved application to conduct the informed consent interview;
 - iv. Principal or faculty co- investigator who attests to the best of his/her knowledge that the informed consent process has been properly conducted and completed.
- j. The UTCOMC/EHS IRB requires the signature of the principal or collaborating investigator within 72 business hours of the subject's entry into the study.
- k. Consent revisions for studies initially approved by the full Board will be reviewed by the full Board unless the changes satisfy criteria for expedited review;
- l. Any IRB approved revisions to the informed consent document that might relate to the subject's willingness to continue participation in the study will necessitate the re-consent of all current subjects in the clinical study. Subjects who have completed the study may be mailed a copy of the changes to the consent document. UTCOMC/EHS IRB does not require re-contacting subjects who have completed their active participation if the revisions do not involve issues pertinent to their health, safety, or well-being. UTCOMC/EHS IRB does not require re-consent of subjects who are still actively

- participating when the revisions will not affect their willingness to continue participation in the study.
 - m. UTCOMC/EHS IRB will affix a stamp on the approved informed consent form with a date of approval and expiration. Only the current stamped, unexpired consent form may be used to secure written documentation of informed consent.
 - n. UTCOMC/EHS requires that the investigator place a copy of the signed informed consent document in the research records for the study. A copy of the consent form must also be provided to the subject or the subject's LAR at the time of consent to participate in the study. A copy of the consent form must also be submitted to the IRB within 72 hours.
 - o. For non-English consent procedures, see SOP IRB #06.
 - p. For pediatric assent, see SOP IRB #13.
 - q. Investigators are required to report any deviations from or violations of the consent policies to the UTCOMC/EHS IRB.
 - r. The UTCOMC/EHS IRB has the right to observe the consent process.
 - s. A copy of any approved current consent form will be kept in the IRB files for the study.
2. IRB review of revisions of consent:
The UTCOMC/EHS IRB will review each informed consent document and revisions to the document to assure that the information contained in the document includes the following elements as required by federal regulations:
- a. A statement that the study involves research;
 - b. An explanation of the purposes of the research;
 - c. The expected duration of the subject's participation;
 - d. Description of the procedures to be followed;
 - e. Identification of any procedures that are experimental;
 - f. A description of any reasonably foreseeable risks or discomforts for the subject, including their probability, magnitude, duration and reversibility;
 - g. A description of any benefits to the subject or to others that may reasonably be expected from the research;
 - h. A disclosure of appropriate alternative procedures or courses of treatment (if any) that may be advantageous to the subject;
 - i. A statement describing the extent to which the confidentiality of research records identifying the subject will be maintained;
 - j. For research involving more than minimal risks, an explanation as to whether any compensation and an explanation as to whether any medical treatments are

- available if injury occurs and, if so, what they consist of, or where further information may be obtained;
- k. An explanation of whom to contact for answers to pertinent questions (*include name(s) and phone number*);
 - i. About the research (the principal investigator);
 - ii. About the subject's rights (the IRB Chair or administrator);
 - iii. Whom to contact in the event of a research-related injury (the principal investigator);
 - l. A statement that participation is voluntary;
 - m. A statement that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled;
 - n. A statement that the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled; subjects should also be informed that they might be asked to permit follow-up if they withdraw;
 - o. A statement that the particular treatment or procedure may involve risks to the subject which are currently unforeseeable;
 - p. A statement that the particular treatment or procedure may involve risks that are currently unforeseeable to an embryo or fetus, if the subject is or may become pregnant, and specific language regarding contraception (including information for male and female participants if applicable);
 - q. A statement of anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent;
 - r. Any additional costs to the subject that may result from participation in the research, including a statement that some insurance and/or other reimbursement plans may not fund or cover care that occurs in a research context;
 - s. Information concerning payment to subjects;
 - t. Incorporation of the HIPAA subject authorization template;
 - u. The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;
 - v. A statement that significant new findings that develop during the research and that may relate to the subject's willingness to continue participation in the study, will be provided to the subject;
 - w. A statement that subjects will be provided a copy of the consent form;

- x. Dated signature lines to permit verification that consent was obtained prior to participation in any study-related procedures; and
 - y. UTCOMC/EHS IRB may require additional information be given to subjects when such information would enhance protection for the rights and welfare of the subject.
3. Consent format
- Requirements for the formatting of informed consent documents include the following:
- a. The consent form must normally be prepared in accord with the UTCOMC/EHS IRB general consent template. If the study involves a specimen repository, then a separate consent form must be prepared according to the UTCOMC/EHS IRB consent template for repositories. If the study involves genetic analysis of predispositions to adult onset diseases, then the consent form must be prepared according to the UTCOMC/EHS IRB template for consent to research involving genetic analysis;
 - b. Number pages 1 of 5, 2 of 5, etc.;
 - c. Insert a line for the research subject's initials or initials of the LAR (____) at the bottom of all pages except the signature page;
 - d. Insert a brief title and principal investigator's name at top of all pages (except title page);
 - e. Add to either the top or bottom of each page of the consent form a "preparation date ____." (This date changes whenever a revision is made to the consent form).
 - f. The document must be written in language understandable to the subjects (for most studies, this would be approximately a 6th grade (12 year old) readability level).
 - g. Consent forms must be written in the second person ("you") except for the sections entitled, "Compensation and Treatment for Injury," and "Consent of Subject," which should be written in the first person ("I").
 - h. The UTCOMC/EHS IRB requires the following signature lines on the informed consent document:
 - i. Signature/date for the subject or subject's LAR; if a LAR is used, then a line must also be included for specifying the relationship of the LAR to the subject;
 - ii. Signature/date for the person obtaining informed consent;
 - iii. Signature/date for the witness;
 - iv. Signature/date for the principal or collaborating investigator; and

- v. Signature/date for the assent of child subjects (if applicable).

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
006: INFORMED CONSENT OF NON-ENGLISH SPEAKING SUBJECTS
AND ILLITERATE ENGLISH-SPEAKING SUBJECTS**

I. PURPOSE

To outline the procedures for UTCOMC/EHS IRB concerning informed consent of subjects who are illiterate or who do not speak English.

II. SCOPE

This SOP applies to the IRB administrator, IRB members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator, Board members and investigators.

III. BACKGROUND

Investigators may not involve a human subject in clinical research without the legally effective informed consent of the subject or the subject's legally authorized representative (LAR). Because legally effective informed consent requires adequate comprehension by the prospective subject or the subject's LAR of the key elements of consent information, the informed consent disclosure must be presented in a language understandable to the subject or the subject's LAR. When it is anticipated that subjects or LARs will be involved who do not speak English as their primary language, a foreign language consent form may be reviewed and approved by the UTCOMC/EHS IRB. Non-English speaking subjects should not be excluded solely on the basis of language.

In accordance with:

45 CFR 46.109; 21 CFR 50.23(a); 21 CFR 50.20 and 50.25; 21 CFR 56.109 and 56.111; 45 CFR 46.111; 45 CFR 46.116; 45 CFR 46.117

FDA IRB Information Sheets: Guide to Informed Consent, 1998 located at <http://www.fda.gov/oc/ohrt/irbs/informedconsent.html>

FDA IRB Information Sheets: Frequently Asked Questions on Informed Consent Process and Informed Consent Document Content, <http://www.fda.gov/oc/ohrt/IRBS/faqs.html>

OHRP Guidance on Informed Consent located at
<http://www.hhs.gov/ohrp/policy/index.html#informed>

OHRP FAQs on Informed Consent located at
<http://www.hhs.gov/ohrp/faq.html>

OHRP Guidance on Informed Consent of Subjects Who Do Not Speak English located at
<http://www.hhs.gov/ohrp/humansubjects/guidance/ic-non-e.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURE

All provisions of the UTCOMC/EHS IRB Informed Consent SOP apply to this SOP.

1. Non-English speaking subjects: Consent written in language understandable to subject (preferred procedure)
 - a. When it is anticipated that subjects or LARs will be involved for whom English is not the primary language, informed consent information and the consent document must be provided in a language understandable to subjects or LARs and contain all elements necessary for legally effective informed consent.
 - b. A non-English certified translation of the English version of the IRB-approved informed consent document will be provided for review and approval by the IRB prior to use with prospective subjects.
 - c. The persons obtaining informed consent must be fluent in both English and the language of the subject or LAR, or be assisted by a certified interpreter. The interpreter must be designated as such a member of the research team. Family or friends of the prospective subject or LAR may not serve as interpreter.
 - d. It is not acceptable for a verbal translation of an English informed consent document to be substituted for a written translation.
 - e. Signatures:
 - i. The person obtaining consent as authorized by the protocol signs the consent form in the language that he/she understands. If the person obtaining consent speaks the

- language of the subject, he/she may sign the foreign language consent.
 - ii. If a certified translator is utilized, the person obtaining consent signs the English version, the translator signs both the English and foreign language version.
 - iii. The subject signs the consent in his/her primary language.
 - iv. When the person obtaining consent is assisted by a translator, the translator may serve as the witness.
 - v. When the EHS translator phone system is used, the phone translator may not serve as the witness; it must be someone in the room.
 - f. After the informed consent signature has been obtained, the subject or his/her LAR will be given a copy of the signed informed consent document.
- 2. Non-English speaking subjects: Use of short form (see algorithm at end of this section; [algorithm and short forms available at IRB website](#)).
- a. In the event that a non-English speaking subject is unexpectedly encountered and there is not a written translation of the informed consent document, an oral translation may be utilized. The PI must carefully consider the risks associated with the research study and whether the non-English speaking subject fully comprehends the risks and benefits of participation. Failure to fully inform the subject or satisfactorily answer all the subject's questions may render the signature on the consent illegal and certainly constitutes an ethical dilemma.
- b. Oral presentation of informed consent information is permitted in conjunction with a short form written consent document (stating that the elements of consent have been presented orally) and a written summary of what is presented orally.
- c. A witness to the oral presentation is required, and the subject must be given copies of the short form document and the summary.

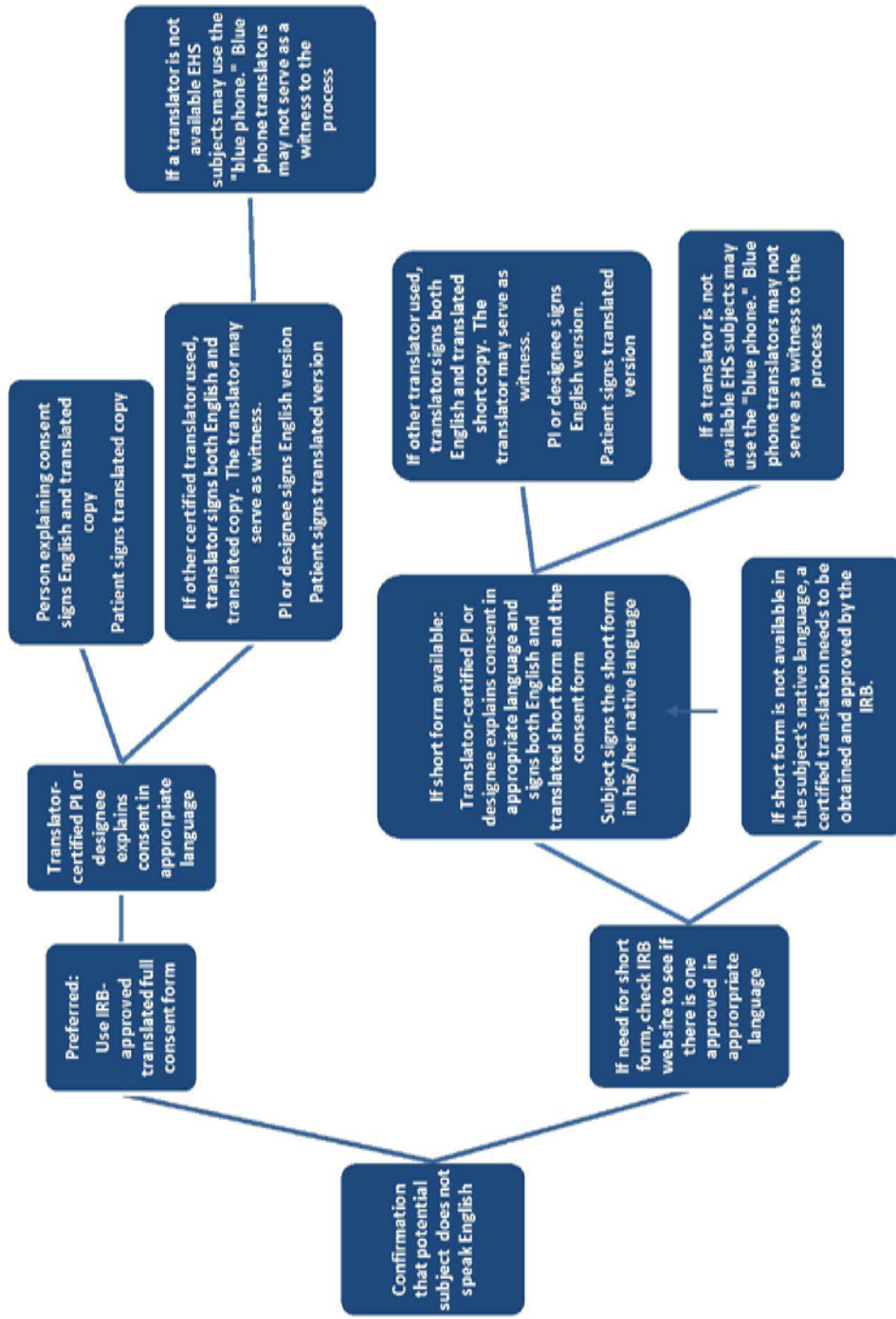
- i. The oral presentation and the short form written document should be in a language understandable to the subject;
 - ii. The summary (i.e., the English language informed consent document) should be signed by the person obtaining consent as authorized under the protocol;
 - iii. The short form document and the summary should be signed by the witness. When the person obtaining consent is assisted by a translator, the translator may serve as the witness.
- d. The IRB must receive all foreign language versions of the short form document as a condition of approval under the provisions of 45 CFR 46.117(b)(2). Expedited review of these versions is acceptable if the protocol, the full English language informed consent document, and the English version of the short form document have already been approved by the convened IRB.
- e. After the informed consent signature has been obtained, the subject (or LAR) will be given a copy of the signed informed consent document and a full copy of the consent in the English language.

3. Illiterate English speaking subjects

- a. Potential subjects who are mentally competent and understand English, but who do not read or write English or are physically disabled may be enrolled in research studies by "making or placing an X" on the consent document in the space for the participant signature after the study information has been reviewed with them.
- b. An impartial witness is to be present to attest to the adequacy of the consent process and the subject's voluntary participation.
- c. The individual obtaining the consent and the witness must sign the consent document in addition to the subject.
- d. Upon verbal explanation, the potential subject should be able to:
 - i. Understand the concepts of the study;
 - ii. Understand the risk(s) and benefit(s) of being in the study;

- iii. Indicate approval or disapproval to enter the study.
- e. The person obtaining the consent should ascertain the above and document the method(s) utilized to communicate with the subject and the method(s) utilized by the subject to communicate agreement to enter the study.
- f. A signed copy of the informed consent document shall be given to the subject or his/her LAR.
- g. Video and audio taping of the process may be utilized with permission of the individual and in accordance with the institution's policies.

Consent Process for Non-English Speaking Subjects



4/27/2012

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
007: EMERGENCY MEDICINE RESEARCH EXEMPTIONS INFORMED
CONSENT REQUIREMENTS**

I. PURPOSE

To outline procedures for the UTCOMC/EHS IRB concerning the review and approval of an exemption from informed consent for emergency medicine research.

II. SCOPE

This SOP applies to all IRB administrator and Board members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members

III. BACKGROUND

The federal regulations for the protection of human research subjects generally require the informed consent of prospective subjects or their legally authorized representatives, although a few narrow exceptions exist. In October of 1996, FDA published a final regulation to amend its regulations to permit a limited class of research in emergency settings without consent. The Department of Health and Human Services simultaneously published waiver criteria that match the FDA requirements. These documents establish a single standard for this class of research

The FDA regulation (21 CFR 50.24) provides a narrow exception to the requirement for informed consent from each human subject prior to initiation of an experimental intervention. The exception applies to a limited class of research activities involving human subjects who are in need of emergency medical intervention but who cannot give informed consent because of their life-threatening medical condition, and who do not have a legally authorized representative available prior to the time when the research interventions must be initiated. The intent of the new regulation is to allow research on life-threatening conditions for which available treatments are unproven or unsatisfactory and where it is not possible to obtain informed consent, while establishing additional protections to provide for safe and ethical conduct of these studies.

FDA recognizes that persons with life-threatening conditions who can neither give informed consent nor refuse enrollment are a vulnerable population. FDA recognizes that the lack of autonomy and inability of subjects to give informed consent requires additional protective procedures in the review, approval, and operation of this research. The exception from the informed consent requirement permitted by the rule is conditional upon documented findings by an IRB. The required findings by the IRB are delineated in the procedures section below.

The provisions at 21 CFR 50.24 for the conduct of emergency medicine research with a waiver of informed consent are distinct from the waiver of informed consent for single patients or subjects as permitted under FDA regulations. The latter regulations apply to situations in which there is a need to use a test article to preserve the life of the patient or subject and it is not possible to secure the consent of the patient or subject prior to its use. Conditions for waiver of consent for emergency use are formulated at 21 CFR 50.23. Emergency use provisions of FDA regulations are addressed in SOP IRB #23.

In accordance with:

Guidance for Institutional Review Boards, Clinical Investigators, and Sponsors: Exception from Informed Consent—Requirements for Emergency Research

<http://fda.gov/OHRMS/DOCKETS/98fr/00805GL.pdf>

FDA Guidance on the Exception from Informed Consent for Studies Conducted in Emergency Settings located at

<http://www.fda.gov/oc/ohrt/irbs/except.html>

OHRP Guidance on Informed Consent Requirements in Emergency Research located at

<http://www.hhs.gov/ohrp/humansubjects/guidance/hsdc97-01.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. IRB review criteria
The IRB may approve an investigation without requiring that informed consent of all research subjects be obtained if the IRB (with the concurrence of a licensed physician who is a member of or consultant to the IRB and who is not otherwise

participating in the clinical investigation) finds and documents each of the following:

- a. The human subjects are in a life-threatening situation, available treatments are unproven or unsatisfactory, and the collection of valid scientific evidence, which may include evidence obtained through randomized placebo-controlled investigations, is necessary to determine the safety and effectiveness of particular interventions;
- b. Obtaining informed consent is not feasible because:
 - i. The subjects will not be able to give their informed consent as a result of their medical condition;
 - ii. The intervention under investigation must be administered before consent from the subjects' legally authorized representatives is feasible; and
 - iii. There is no reasonable way to identify prospectively the individuals likely to become eligible for participation in the clinical investigation.
- c. Participation in the research holds out the prospect of direct benefit to the subjects because:
 - i. Subjects are facing a life-threatening situation that necessitates intervention;
 - ii. Appropriate animal and other preclinical studies have been conducted, and the information derived from those studies and evidence support the potential for the intervention to provide a direct benefit to the individual subjects; and
 - iii. Risks associated with the investigation are reasonable in relation to what is known about the medical condition of the potential class of subjects, the risks and benefits of standard therapy, if any, and what is known about the risks and benefits of the proposed intervention or activity.
- d. The clinical investigation could not practicably be carried out without the waiver.
- e. The proposed investigational plan defines the length of the potential therapeutic window based on scientific evidence, and the investigator has committed to attempting to contact a legally authorized representative for each subject within that window of time and, if feasible, to asking the legally authorized representative contacted for consent within that window rather than proceeding without consent. The investigator will summarize efforts made to contact legally authorized representatives and make this

information available to the IRB at the time of continuing review.

- f. The IRB has reviewed and approved informed consent procedures and an informed consent document consistent with 21 CFR 50.25. These procedures and the informed consent document are to be used with subjects or their legally authorized representatives in situations where use of such procedures and documents is feasible. The IRB has reviewed and approved procedures and information to be used when providing an opportunity for a family member to object to a subject's participation in the clinical investigation consistent with paragraph (1)(g)(v) of this section.
- g. Additional protections of the rights and welfare of the subjects will be provided, including, at least:
 - i. Consultation (including, where appropriate, consultation carried out by the IRB) with representatives of the communities in which the clinical investigation will be conducted and from which the subjects will be drawn;
 - ii. Public disclosure to the communities in which the clinical investigation will be conducted and from which the subjects will be drawn, prior to initiation of the clinical investigation, of plans for the investigation and its risks and expected benefits;
 - iii. Public disclosure of sufficient information following completion of the clinical investigation to apprise the community and researchers of the study, including the demographic characteristics of the research population, and its results;
 - iv. Establishment of an independent data monitoring committee to exercise oversight of the clinical investigation; and
 - v. If obtaining informed consent is not feasible and a legally authorized representative is not reasonably available, the investigator has committed, if feasible, to attempting to contact within the therapeutic window the subject's family member who is not a legally authorized representative, and asking whether he or she objects to the subject's participation in the clinical investigation. The investigator will summarize efforts made to contact family members and make this information available to the IRB at the time of continuing review.

2. Surrogate for consent

The IRB is responsible for ensuring that procedures are in place to inform at the earliest feasible opportunity, each subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, of the subject's inclusion in the clinical investigation, the details of the investigation and other information contained in the informed consent document. The IRB shall also ensure that there is a procedure to inform the subject, or if the subject remains incapacitated, a legally authorized representative of the subject, or if such a representative is not reasonably available, a family member, that he or she may discontinue the subject's participation at any time without penalty or loss of benefits to which the subject is otherwise entitled. If a legally authorized representative or family member is told about the clinical investigation and the subject's condition improves, the subject is also to be informed as soon as feasible. If a subject is entered into a clinical investigation with waived consent and the subject dies before a legally authorized representative or family member can be contacted, information about the clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.

3. Record retention

The IRB determinations required by paragraph (1) of this section and the documentation required by paragraph (5) of this section are to be retained by the IRB for at least three years after completion of the clinical investigation, and the records shall be accessible for inspection and copying by the FDA in accordance with 21 CFR 56.115(b).

4. IND/IDE

Protocols involving an exception to the informed consent requirement under this section must be performed under a separate investigational new drug application (IND) or investigational device exemption (IDE) that clearly identifies such protocols as protocols that may include subjects who are unable to consent. The submission of those protocols in a separate IND/IDE is required even if an IND for the same drug product or an IDE for the same device already exists. Applications for investigations under this section may not be submitted as amendments under 21 CFR 312.30 or 812.35.

5. IRB Disapproval

If the IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in the exception provided under part (1) of this section

or because of other relevant ethical concerns, the IRB will document its findings and provide these findings promptly in writing to the clinical investigator and to the sponsor of the clinical investigation. The sponsor of the clinical investigation must promptly disclose this information to FDA and to the sponsor's clinical investigators who are participating or are asked to participate in this or a substantially equivalent clinical investigation of the sponsor, and to other IRBs that have been, or are, asked to review this or a substantially equivalent investigation by the sponsor.

6. Recordkeeping

The following recordkeeping requirements will be observed:

- a. IRB decisions will be communicated to the investigator in writing;
- b. Should the IRB not approve a waiver of consent, documentation will be provided to the investigator in writing.
- c. All correspondence and documentation will be kept in the files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
008: CONFIDENTIALITY IN HUMAN SUBJECT RESEARCH
PARTICIPATION**

I. PURPOSE

To document the policy and procedures used by the UTCOMC/EHS IRB regarding the confidentiality of human subject participation.

II. SCOPE

This SOP applies to the IRB administrator and Board members.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members

III. BACKGROUND

Confidentiality refers to the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others without express permission. The duty to protect confidential information reflects the right of persons to control access to information about themselves. Unauthorized disclosure of confidential information not only violates this right, but may place individuals at risk of damage to their financial standing, employability, or reputation, as well as place them at risk of criminal or civil liability.

HHS and FDA regulations for the protection of human subjects specify that IRB approval of research is contingent on the finding that "there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data." In addition, requirements for information disclosure in the informed consent process include "a statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained."

It is the policy of the UTCOMC/EHS IRB that clinical research studies include provisions for the protection of subject confidentiality to be addressed in a separate section in all informed consent documents reviewed by the UTCOMC/EHS IRB.

In accordance with:

45 CFR 46; 21 CFR 50, 56

OHRP IRB Guidance on Federal Certificates of Confidentiality located at <http://www.hhs.gov/ohrp/humansubjects/guidance/certconf.htm>.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. IRB Review, [Form A](#)
The UTCOMC/EHS IRB will review the confidentiality section of all Initial Approval Forms ([Form A](#)) to determine whether the provisions for and limitations on confidentiality delineated therein are consistent with the requirements of HHS regulations and all institutional, local, state and federal policies, regulations and laws (including the HIPAA regulations). The confidentiality section must define the manner in which subject identifiers will be used in research records, explain whether information about the subject's research participation will be placed in the medical record, include the HIPAA template securing subject authorization for the use of protected health information, and provide assurance that subjects will not be identified in any presentations or publications based on the results of the research.
2. IRB Review, Consent Forms
The UTCOMC/EHS IRB will review all submitted informed consent documents to ensure that the confidentiality section explains the provisions for and limitations on confidentiality pursuant to the requirements of HHS regulations and all institutional, local, state or federal policies, regulations and laws (including HIPAA regulations). The section on confidentiality must define the manner in which subject identifiers will be used in research records, explain whether information about the subject's research participation will be placed in the medical record, include the HIPAA template securing subject authorization for the use of protected health information, and provide assurance that subjects will not be identified in any presentations or publications based on the results of the research.
3. Disclosure to Subject
UTCOMC/EHS IRB requires disclosure to the subject about any foreseeable circumstances under which the investigator may be required to disclose protected health information (PHI) to a third party (e.g., mandatory reporting of infectious diseases, mandatory reporting of suspected child abuse, etc.).

4. Questionnaires, Surveys
In addition, the UTCOMC/EHS IRB will review questionnaires, data collection tools, surveys, and other methods used in the study to collect information to determine the type and means of obtaining information from and about subjects.
5. Certificate of Confidentiality
UTCOMC/EHS IRB may require researchers to obtain a certificate of confidentiality should the study involve the collection of information about sensitive, stigmatizing or illegal activities. Certificates of confidentiality ensure that investigators cannot be compelled to disclose confidential research data under legal compulsion. "Sensitive" research includes, but is not limited to, the collection of information falling into any of the following categories:
 - a. Information relating to sexual attitudes, preferences or practices;
 - b. Information relating to the use of alcohol, drugs or other addictive products;
 - c. Information pertaining to illegal conduct;
 - d. Information that if released could reasonably be damaging to an individual's financial standing, employability, or reputation within the community;
 - e. Information that would normally be recorded in a patient's medical record and the disclosure of which could reasonably lead to social stigmatization or discrimination;
 - f. Information pertaining to an individual's psychological well-being or mental health; and
 - g. Information pertaining to the diagnosis and/or treatment of communicable diseases.
6. Certificates of Confidentiality—Mental Disorders & Abuse
Investigators must request a certificate of confidentiality from the appropriate federal official. For research involving mental disorders or substance abuse, they must contact the National Institute on Alcohol Abuse and Alcoholism, the National Institute on Drug Abuse or the National Institute of Mental Health. The Assistant Secretary of Health issues certificates of confidentiality for biomedical, behavioral, clinical, or other research that does not fall into these categories.
7. Certificate Submission to IRB
Investigators will be asked to supply UTCOMC/EHS IRB with a copy of any certificate of confidentiality obtained.
8. Record Retention

The confidentiality of research subjects shall also be maintained when any study information is kept by recorded means such as audio or videotapes. The investigator is required to tell the subject how his/her identity will be or will not be disclosed in these instances, when the tapes may be used for other broadcasts or educational purposes, and when such recorded information shall be accessed, stored, and/or destroyed.

9. Recording and Broadcasting

Live case recording or broadcast (including photography) of clinical research must have prior IRB approval. In all events, the research consent will be modified to contain additional language regarding the taping/photography, and any additional risks to the subject due to the taping/live broadcast (such as increased procedure time, increased anesthesia time, loss of confidentiality, etc.).

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
009: PROTECTED HEALTH INFORMATION IN RESEARCH**

I. PURPOSE

To provide guidance to investigators for securing subject authorization for use of protected health information (PHI) in human research studies.

II. SCOPE

This SOP applies to IRB members and investigator

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that persons provide authorization for the use of PHI for specific purposes other than treatment, payment or health care operations. Specific authorization is generally required for the use and disclosure of PHI in research studies. The IRB requires incorporation of HIPAA authorization language in the body of the informed consent document.

The basic elements of information that must be provided in writing to prospective subjects in securing their authorization for the research use of their PHI are specified in the privacy regulations. They include the following elements

1. A description of the information to be used or disclosed that identifies the information "in a specific and meaningful fashion;"
2. The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure;
3. The name or other specific identification of the person(s), or class of persons, to whom the covered entity is permitted to make the requested use or disclosure;
4. A description of each purpose for the requested use or disclosure;
5. An expiration date or an expiration event that relates to the purpose of the use or disclosure; the expiration date may be specified as "end of the research study," or as "none" in the

- event that the PHI will be used for an indefinite period as part of a research database or repository;
6. A description of the individual's right to revoke the authorization in writing, including limitations on this right, and an explanation of how the individual may revoke the authorization; in explaining limitations on the right to revoke the authorization, investigators must indicate that the Privacy Rule permits the continued research use and disclosure of PHI obtained from the subject prior to the time when the authorization is revoked;
 7. An explanation that the investigator may condition research participation on the provision of the authorization and that subjects who revoke the authorization may be withdrawn from the study.
 8. The potential for information disclosed pursuant to the authorization to be subject to re-disclosure by the recipient and no longer protected by the Privacy Rule; and
 9. When the research includes evaluation of a treatment, a statement that the subject's access to PHI will be temporarily suspended as long as the research is in progress, but will be reinstated upon completion of the research; this ground for the denial of access does not apply to research in which treatment is not evaluated.

Several other regulatory requirements for authorizations must also be noted.

1. The authorization must be signed and dated by the subject or the subject's legally authorized representative.
2. If the signature is secured from the subject's legally authorized representative, then a description of the representative's authority to act on the individual's behalf must also be provided. This provision requires that, for studies in which personal representatives may be providing consent or permission for some subjects, a separate line must be inserted in the signature section of the research consent form for describing the relationship of the representative to the subject.
3. When the authorization is included in the consent form for the research study, a copy of the consent form must be provided to the subject or the subject's legally authorized representative.
4. Signed consent forms including the authorization must be retained for at least six years.

In accordance with:

45 CFR 160, 164; <http://www.hhs.gov/policies/index.html#hippa>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Application
When a study is submitted for full Board or expedited review, the confidentiality section of the project descriptors must specify the plan for securing the HIPAA authorization of prospective subjects as part of the informed consent process.
2. Required language

The following HIPAA authorization language must be inserted at the appropriate location in the confidentiality section of the consent document. The material in block form is the required authorization language. The *italicized* material in parentheses provides directions for including material that may or may not be relevant for particular studies. The italicized material should not be retained in the authorization language as it appears in the consent form.

“Your Privacy Rights

Under federal privacy regulations you have the right to determine who has access to your personal health information (called “protected health information” or PHI). PHI collected in this study may include your medical history, the results of physical exams, lab tests, x-ray exams, and other diagnostic and treatment procedures. Basic information about you such as age, race, where you live or other similar information may be collected and is considered PHI.

Who Can See Your Records?

By signing this consent form, you are authorizing the researchers at the *(insert the name of the institution)* to have access to your PHI collected in this study *(if the study will use PHI in the possession of another covered entity, add)* and to receive your PHI from *(either)* your physician *(and/or)* facilities where you have received health care. *(If any of the following individuals or entities will also be reviewing the PHI collected or received for the study, then add the following sentence.)* In addition, other persons involved in doing and supervising this

research may see your PHI, including *(if the study is multi-institutional, add)*, including researchers at *(name of the institutions)*; *(if a cooperative group study, add)* *(name of the cooperative group)*; *(if the research involves an FDA-regulated drug, device or biologic add)* *(The Food and Drug Administration, FDA)*; and *(if claims for some of the procedures performed during the study will be submitted to third party payers, add)* your medical insurance company. *(If the research is sponsored, add)*. Your PHI may also be seen by *(name of sponsor)*, which sponsors and pays for this research; *(name of CRO, if applicable)* which has been hired by the sponsor to run the study, and a Data and Safety Monitoring Committee *(if applicable)*. *(If the previous sentence was used, add the following sentence as well)*. However, some of these organizations may not be required to protect your PHI.

Who Protects Your Rights?

The Institutional Review Board (IRB), a group of people who review research work at the University of Tennessee College of Medicine Chattanooga/Erlanger Health System, may review your PHI as part of its job to protect the rights and welfare of research subjects. Your PHI will not be shown to any other person: 1) except as required by law or, 2) for authorized oversight of this research study by other regulatory agencies, or 3) for other research which has been approved by the IRB. Your PHI will be used only for the research described in this consent form. Your PHI may be used *(either)* until the study is completed *(or if the research is FDA regulated)* for as long as the sponsor reports study data to the FDA *(or if the research is without a foreseeable endpoint, such as a repository or a registry)* indefinitely.

Can You Cancel This Consent?

You may cancel this permission in writing at any time by contacting the principal investigator listed on the first page of the consent form. If you cancel the permission, your PHI may still be used if it was obtained before the cancellation, and its use is necessary to finish the research. However, PHI collected after your cancellation may not be used in the study. If you refuse to provide this authorization, PHI may not be used in the study. If you choose to cancel this permission, you must do so in writing to the principal investigator at the following address *(list investigator address)*.

What If You Refuse to Sign?

If you refuse to provide this permission, you will not be able to participate in the research study. If you cancel the permission, then you will be withdrawn from the study.

Finally, the federal regulations allow you to obtain access to your PHI collected or used in this study. *(If the research study includes treatment of subjects, add the following sentences.)* However, in order to complete the research, your access to this PHI may be temporarily suspended while the research is in progress. When the study is completed, your right of access to this information will be reinstated."

3. Template language

In general, the language in the HIPAA authorization template should be precisely followed. Minor changes to the template, inserted at the request of study sponsors, are permissible with the review and approval of the IRB and the legal department of the institution in which the research is conducted. Use of sponsor recommended HIPAA authorization templates in place of or in addition to the RIB template is not permitted.

4. HIPAA language in consent form

The HIPAA authorization template must be placed in the confidentiality section of all consent forms unless the investigator has received IRB approval to use PHI in research without the authorization of the subject.

5. Record retention

Investigators must maintain documentation that subjects have provided a HIPAA authorization for the research use of their PHI for at least six years. If the sponsor, governmental regulatory agency, IRB or institution requires that research documents/materials be retained for longer than six years, the longer period of retention prevails.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
010: USE OF PROTECTED HEALTH INFORMATION WITHOUT
SUBJECT AUTHORIZATION**

I. PURPOSE

To provide guidance to investigators regarding the conditions under which protected health information (PHI) may be used in research without the authorization of subjects.

II. SCOPE

This SOP applies to IRB members and investigators

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that persons provide authorization for the use of PHI for specific purposes other than treatment, payment or health care operations. Specific authorization is generally required for the use and disclosure of PHI in research studies. However, HIPAA also permits the research use of PHI without subject authorization under specific conditions. These conditions include review of PHI preparatory to research, research involving subjects who are decedents, research involving the use of limited data sets or de-identified data, and research in which a waiver or alteration of authorization is granted by the IRB. Further information about the conditions under which PHI may be used without subject authorization can be obtained from the UTHSC IRB guidance document entitled, "[HIPAA Guidance Procedures](#)." Or by consulting the legal departments of the institutions in which the research is conducted. Requests to use PHI for research purposes without subject authorization must be submitted to the IRB for approval prior to initiation.

In accordance with:

45 CFR 160, 164;

<http://www.hhs.gov/ohrp/humansubjects/guidance/hsdc97-01.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

Definitions

De-identified data means that the source material used by an investigator (as contrasted with the data as abstracted) does not include any of the following 18 categories of personal identifiers of individuals, or of the relatives, employers or household members of such individuals:

1. Names;
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, and their equivalent geocodes, except for the initial three digits of a zip code if the geographic unit represented by these three initial digits contains more than 20,000 people;
3. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death, and all ages over 89 and all elements of dates indicative of age over 89, except that such ages and elements may be aggregated into a single category of age 90 or older;
4. Telephone numbers;
5. Fax numbers;
6. Electronic mail addresses;
7. Social security numbers;
8. Medical record numbers;
9. Health plan beneficiary numbers;
10. Account numbers;
11. Certificate/license numbers;
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web universal resource locators (URLs);
15. Internet protocol (IP) address numbers
16. Biometric identifiers, including finger and voice prints;
17. Full face photographic images and any comparable images; and
18. Any other unique identifying number, characteristic, or code.

Limited Data Set means that the source material used by an investigator (as contrasted with the data as abstracted) does not include any of the following direct identifiers of the individual or of relatives, employers, or household members of the individual:

1. Names;
2. Postal address information, other than town or city, state and zip code;

3. Telephone numbers;
4. Fax numbers;
5. Electronic mail addresses;
6. Social security numbers;
7. Medical record numbers;
8. Health plan beneficiary numbers;
9. Account numbers;
10. Certificate/license numbers
11. Vehicle identifiers and serial numbers, including license plate numbers;
12. Device identifiers and serial numbers;
13. Web universal resource locators (URLs);
14. Internet protocol (IP) address numbers;
15. Biometric identifiers, including finger and voice prints; and
16. Full face photographic images and any comparable images.

IV. PROCEDURES

1. Form H Submission

Any proposal for research use of PHI without the authorization of the subject must be submitted for IRB review using [Form H](#), "HIPAA Waiver of Authorization." Request for the research use of PHI without subject authorization will be approved only if one of the following regulatory categories applies:

 - a. The use and disclosure of PHI for research purposes qualifies for a waiver or alteration of subject authorization. Such research purposes include the use of PHI in identifying potential subjects for recruitment, in contacting potential subjects regarding study participation, and in conducting the study itself. The investigator must document the following conditions on [Form H](#):
 - i. There is no more than minimal risk to the privacy of individual subjects based on the presence of the following elements:
 - A. An adequate plan to protect the identifiers from improper use and disclosure;
 - B. An adequate plan to destroy the identifiers at the earliest opportunity consistent with the conduct of the research, unless there is a health or research justification for retaining identifiers or such retention is otherwise required by law; and

- C. An adequate written assurance (provided in [Form H](#)) that the PHI will not be reused or disclosed to any other person or entity, except as required by law, or for authorized oversight of the research study, or for other research for which the use or disclosure is permitted without authorization;
 - ii. It is not practicable to conduct the research without the waiver or alteration of the authorization requirement; and
 - iii. It is not practicable to conduct the research without access to and use of the PHI for which the waiver or alteration of the authorization requirement is sought.
- b. All PHI to be used in the study is from deceased individuals. Qualification under this category requires that the researcher document the following in [Form H](#):
 - i. The use or disclosure is sought solely for research on the PHI of decedents;
 - ii. Adequate documentation exists that all subjects are deceased; and at the request of the covered entity from which the PHI is sought, documentation will be provided to it that all subjects are deceased; and
 - iii. Use of the PHI is necessary for the research purposes.
- c. The PHI to be used in the study involves a “limited data set.” The investigator must address the following items using [Form H](#):
 - i. The PHI used in the research excludes the 16 categories of direct identifiers necessary for the creation of a limited data set;
 - ii. A data use agreement, satisfying the requirements of the HIPAA regulations, has been reached with the entity holding the PHI;
 - iii. A copy of the data use agreement must be submitted with the application or prior to final IRB approval for the research use of PHI without the subject’s authorization.
- d. The investigator’s source materials (as contrasted with the data abstracted) constitute “de-identified data” as defined in the HIPAA regulations. The investigator must address the following items:

- i. It must be explained that the data has been determined to be de-identified either by a qualified and independent expert in biostatistics or by the exclusion from the data of all 18 categories of direct identifiers specified in the regulations;
 - ii. If the entity which maintains the health information will utilize a code of other means to re-identify the records, then it must be certified that the code or other means used to re-identify the records is not derived from or related to the individuals, or otherwise capable of being translated to identify individual subjects; and
 - iii. It must be verified that the entity maintaining the records will not disclose to the investigator the means used for re-identifying the records.
- e. The PHI will be used for a review preparatory to research. The investigator must document the following points:
- i. The use or disclosure is being sought solely to review PHI as necessary to prepare a research protocol or for similar purposes preparatory to research;
 - ii. No PHI will be copied or removed by the investigator in the course of the review from the entity which maintains the PHI; and
 - iii. Use of the PHI is necessary for purposes that are preparatory to research.

2. IRB approval letter

UTCOMC/EHS IRB will include the following in its letter to the investigator indicating that it has approved the research use of PHI without subject authorization:

- a. The name of the study and the assigned IRB number;
- b. The date of the action;
- c. Specific criteria that have been satisfied for research use of PHI without subject authorization;
- d. Description of the PHI for which use or access has been determined to be necessary;
- e. Review and approval procedures used; and
- f. Signature of IRB Chair or designee.

3. Record retention

UTCOMC/EHS IRB will maintain such documentation for at least six years.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
011: REVIEW OF RESEARCH—ADDITIONAL PROTECTIONS FOR
VULNERABLE SUBJECTS—PREGNANT WOMEN AND FETUSES**

I. PURPOSE

To document the policy and procedures used by the UTCOMC/EHS IRB regarding the review of clinical studies involving pregnant women and fetuses.

II. SCOPE

This SOP applies to the IRB administrator, IRB members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

The IRB has the responsibility to assure that the rights and welfare of subjects are adequately protected. As research subjects, pregnant women, fetuses and neonates possess special vulnerabilities. These vulnerabilities relate to an increased susceptibility to harm associated with research procedures, as well as impediments to provision of adequate informed consent (e.g., women in labor) or the absence of the ability to provide informed consent (fetuses and neonates). Therefore, additional protections are afforded them as research subjects.

Research with pregnant women, fetuses and neonates must satisfy the regulatory requirements of 45 CFR 46, Subpart B, "Additional Protections for Pregnant Women, Human Fetuses and Neonates Involved in Research," as well as the general requirements of 45 CFR 46, Subpart A (the Common Rule). In addition to the requirements outlined in the SOP 03 (Review of Research), UTCOMC/EHS IRB shall determine that research with pregnant women, fetuses, and neonates is conducted in accord with 45 CFR 46, Subpart B. Finally, if a neonate is viable, then it may be included in research only to the extent permitted by the requirements of 45 CFR 46, Subpart D, "Additional Protections for Children Involved as Subjects in Research," and the requirements of the UTCOMC/EHS IRB as outlined in IRB SOP #13.

In accordance with:

45 CFR 46, Subparts B and D; OHRP Guidance on Written IRB Procedures, 1/15/07.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

Definitions

Dead fetus, exhibits neither heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord.

Delivery: Complete separation of the fetus from the woman by expulsion or extraction or any other means.

Fetus: The product of conception from implantation until delivery.

Neonate: Newborn

Nonviable neonate: A newborn after delivery that, although living, is not viable.

Pregnancy: The period of time from implantation until delivery. A woman shall be assumed to be pregnant if she exhibits any of the pertinent presumptive signs of pregnancy, such as missed menses, until the results of a pregnancy test are negative or until delivery.

Viable: As it pertains to the neonate, means being able, after delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration.

IV. PROCEDURES

1. Pregnant women or fetuses criteria
Pregnant women or fetuses may be involved in research if all of the following conditions are met:
 - a. Where scientifically appropriate, preclinical studies, including studies in pregnant animals, and clinical studies, including studies on non-pregnant women, have been conducted and provide data for assessing potential risks to pregnant women and fetuses;
 - b. The risk to the fetus is caused solely by interventions or procedures that hold out the prospect of direct benefit for the woman or the fetus; or, if there is no such prospect of benefit, the risk to the fetus is not greater

- than minimal and the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means;
- c. Any risk is the least possible for achieving the objectives of the research;
 - d. If the research holds out the prospect of direct benefit to the pregnant woman, the prospect of a direct benefit both to the pregnant woman and the fetus, or no prospect of benefit for the woman nor the fetus when risk to the fetus is not greater than minimal and the purpose of the research is the development of important biomedical knowledge that cannot be obtained by any other means, her consent is obtained in accord with the informed consent provisions of subpart A of 45 CFR 46;
 - e. If the research holds out the prospect of direct benefit solely to the fetus then the consent of the pregnant woman and the father is obtained in accord with the informed consent provisions of subpart A of 45 CFR 46, except that the father's consent need not be obtained if he is unable to consent because of unavailability, incompetence, or temporary incapacity or the pregnancy resulted from rape or incest;
 - f. Each individual providing consent under paragraph (d) or (e) of this section is fully informed regarding the reasonably foreseeable impact of the research on the fetus or neonate;
 - g. For children, as defined in 45 CFR 46.402(a), who are pregnant, assent and permission are obtained in accord with the provisions of subpart D of this part;
 - h. No inducements, monetary or otherwise, will be offered to terminate a pregnancy;
 - i. Individuals engaged in the research will have no part in any decisions as to the timing, method, or procedures used to terminate a pregnancy; and
 - j. Individuals engaged in the research will have no part in determining the viability of a neonate.

2. Special conditions

Special conditions must also be satisfied for IRB approval of research involving certain categories of neonates:

- a. Neonates of uncertain viability and nonviable neonates may be involved in research if all of the following conditions are met:
 - i. Where scientifically appropriate, preclinical and clinical studies have been conducted and provide data for assessing potential risks to neonates;
 - ii. Each individual providing consent under paragraph (b)(2) or (c)(5) of this section is fully

- informed regarding the reasonably foreseeable impact of the research on the neonate;
 - iii. Individuals engaged in the research will have no part in determining the viability of a neonate;
 - iv. The requirements of paragraph (b) or (c) of this section have been met as applicable.
 - b. Neonates of uncertain viability: Until it has been ascertained whether or not a neonate is viable, a neonate may not be involved in research covered by this subpart unless the following additional conditions have been met:
 - i. The IRB determines that:
 - A. The research holds out the prospect of enhancing the probability of survival of the neonate to the point of viability, and any risk is the least possible for achieving that objective, or
 - B. The purpose of the research is the development of important biomedical knowledge which cannot be obtained by other means and there will be no added risk to the neonate resulting from the research; and
 - ii. The legally effective informed consent of either parent of the neonate or, if neither parent is able to consent because of unavailability, incompetence, or temporary incapacity, the legally effective informed consent of either parent's legally authorized representative is obtained in accord with subpart A of 45 CFR 46, except that the consent of the father or his legally authorized representative need not be obtained if the pregnancy resulted from rape or incest.
 - c. Nonviable neonates: After delivery, a nonviable neonate may not be involved in research covered by this subpart unless all of the following additional conditions are met:
 - i. Vital functions of the neonate will not be artificially maintained;
 - ii. The research will not terminate the heartbeat or respiration of the neonate;
 - iii. There will be no added risk to the neonate resulting from the research;
 - iv. The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
 - v. The legally effective informed consent of both parents of the neonate is obtained in accord with

subpart A of 45 CFR 46.116© and (d) do not apply. However, if either parent is unable to consent because of unavailability, incompetence, or temporary incapacity, the informed consent of one parent of a nonviable neonate will suffice to meet the requirements of this paragraph(c)(v), except that the consent of the father need not be obtained if the pregnancy resulted from rape or incest. The consent of a legally authorized representative of either or both of the parents of a nonviable neonate will not suffice to meet the requirements of this paragraph (c)(v).

- d. Viable neonates: A neonate, after delivery, that has been determined to be viable may be included in research only to the extent permitted by and in accord with the requirements of subparts A and D of 45 CFR 46.

3. Placenta, deceased fetus, tissue

The IRB will approve research involving, after delivery, the placenta, the deceased fetus or fetal material in accord with the following requirements:

- a. Research involving, after delivery, the placenta; the dead fetus; macerated fetal material; or cells, tissue, or organs excised from a dead fetus, shall be conducted only in accord with any applicable federal, state, or local laws and regulations regarding such activities;
- b. If information associated with material described in paragraph (a) of this section is recorded for research purposes in a manner that living individuals can be identified, directly or through identifiers linked to those individuals, those individuals are research subjects and all pertinent subparts of 45 CFR 46 are applicable.

4. DHHS Secretary review

When research is not otherwise approvable under 45 CFR 46.204 or 45 CFR 205, but may present an opportunity to understand, prevent, or alleviate a serious problem effecting the health or welfare of pregnant women, fetuses, or neonates, then the IRB will observe the following procedures:

The Secretary will conduct or fund research that the IRB does not believe meets the requirements of Sec. 46.204 or Sec.46.205 only if:

- a. The IRB will determine whether the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem effecting the health or welfare of pregnant women, fetuses, or neonates. If the finding is positive, then the IRB will

request that the Secretary of HHS convene an expert panel in accord with 45 CFR 46.207.

- b. The IRB will approve such research if the Secretary, after consultation with a panel of experts in pertinent disciplines (for example science, medicine, ethics, law) and following opportunity for public review and comment, including a public meeting announced in the Federal Register, has determined either:
 - i. That the research in fact satisfies the conditions of Sec. 46.204, as applicable; or
 - ii. The following:
 - A. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem effecting the health or welfare of pregnant women, fetuses or neonates;
 - B. The research will be conducted in accord with sound ethical principles; and
 - C. Informed consent will be obtained in accord with the informed consent provisions of subpart A and other applicable subparts of 45CFR46.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
012: REVIEW OF RESEARCH—ADDITIONAL PROTECTIONS FOR
PRISONERS**

I. PURPOSE

To document the policy and procedures used by the UTCOMC/EHS IRB regarding the review of clinical studies involving prisoners.

II. SCOPE

This SOP applies to the IRB administrator, IRB members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

Insofar as incarceration places prisoners under constraints that may affect their ability to make truly voluntary and uncoerced decisions about whether or not to participate as subjects in research, they constitute a vulnerable population for which additional protections are warranted. In addition to the responsibilities outlined in SOP 03 (Review of Research), the UTCOMC/EHS IRB shall determine whether proposed studies with prisoners also satisfy the conditions enumerated at 45 CFR 46 Subpart C, "Additional Protections Pertaining to Biomedical and Behavioral Research Involving Prisoners as Subjects." These provisions of the federal regulations are intended to assure that prisoners provide voluntary consent to participation in research, that their confidentiality is rigorously protected, and that prisoners are not used as subjects in studies for which non-incarcerated subjects are suitable. They apply whether the research involves individuals who are prisoners at the time of enrollment in the research or who become prisoners after they become enrolled in the research. DHHS also requires that the IRB have among its members one or more individuals knowledgeable about and experienced in working with prisoners when research involving prisoners is to be reviewed.

In accordance with:

45 CFR 46, Subpart C; OHRP Guidance on Written IRB Procedures
1/15/07

OHRP Guidance on the Involvement of Prisoners in Research located at <http://www.hhs.gov/ohrp/humansubjects/guidance/prisoner/htm>

OHRP FAQs on Prisoner Research located at <http://www.hhs.gov/ohrp/prisonerfaq.html>.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

Definitions:

Prisoner: An individual involuntarily confined or detained in a penal institution, including persons:

1. Sentenced to such an institution under a criminal or civil statute;
2. Detained pending arraignment, trial or sentencing; and
3. Detained in other facilities (e.g. for the treatment of drug detoxification or alcoholism) under statutes or commitment procedures providing such alternatives to criminal prosecution or incarceration in a penal institution; and
4. Individuals detained pending arraignment, trial or sentencing (45 CFR 46.303(c)).

Minimal risk: The probability and magnitude of physical or psychological harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of healthy persons.

IV. PROCEDURES

1. IRB review criteria
For research conducted or supported by DHHS to involve prisoners, the following conditions must occur:
 - a. The institution engaged in the research must certify to the Secretary of HHS (through OHRP) that the proposed research falls within the categories of research permitted under 45 CFR 46.306(a)(2); and
 - b. The Secretary must determine that the proposed research falls within one of the categories of permissible research specified in 45 CFR 46.306(a)(2);
 - c. The IRB letter to OHRP will include:
 - i. Name and address of the institution;
 - ii. Protocol name/number and any relevant HHS grant application or protocol;

- iii. Notification of the name and qualifications of the prisoner representative if the approved IRB roster does not already reflect this information;
 - iv. The IRB's determination regarding the seven additional findings under 45 CFR 46.305 and the specific category under which the research is authorized according to 45 CFR 46.306;
 - v. A brief description of the research sufficient to allow OHRP to determine whether or not to concur with the IRB, and whether OHRP needs to consult with appropriate experts and publish a Federal Register Notice;
- d. Prisoner research certification letters will be mailed to:

Attention: OHRP Prisoner Research Contact Person
 Office for Human Research Protections
 Department of Health and Human Services
 The Tower Building
 1101 Wooten Parkway, Suite 200
 Rockville, MD 20852.

The IRB will keep a copy of this letter in the files for the study.

2. IRB composition

During the review of any study involving the potential for enrollment of prisoners, in addition to normal review procedures, UTCOMC/EHS IRB will consider the following:

- a. IRB Membership: The composition of the IRB must satisfy the requirements of HHS regulations at 45 CFR 46.304 for IRB review of a protocol involving prisoners as subjects that is conducted or is supported by HHS, including the following:
 - i. A majority of the IRB (exclusive of prisoner members) shall have no association with the prison(s) involved, apart from their membership on the IRB;
 - ii. At least one IRB member must be a prisoner, or a prisoner representative with appropriate background, experience or working knowledge, understanding and appreciation of prison conditions from the perspective of the prisoner to serve in that capacity. The IRB must possess and maintain the CV of the prisoner or prisoner representative serving on the IRB.
 - iii. Where a particular research project is reviewed by more than one IRB, only one IRB need satisfy this requirement.

- iv. These requirements must be met during all types of protocol review including initial review, continuing review, review of protocol revisions and review of reports of unanticipated problems involving risks to subjects;
 - b. The IRB must notify OHRP of any change in the IRB roster occasioned by the addition of a prisoner or a prisoner representative as required by 45 CFR 46.103(b)(3).
 - c. Applicable State Laws: UTCOMC/EHS IRB will consider applicable state laws in the review of these studies.
3. Additional IRB duties IRB when prisoners are involved
- a. When the IRB reviews a protocol in which a prisoner is a subject, the IRB must make and document, in addition to other requirements under 45 CFR 46, subpart A, seven additional findings under 45 CFR 46.305(a); as follows:
 - i. The research under review represents one of the categories of research permissible under 45 CFR 46.306(a)(2);
 - ii. Any possible advantages accruing to the prisoner through his or her participation in the research, when compared to the general living conditions, medical care, quality of food, amenities and opportunity for earnings in the prison, are not of such a magnitude that his/her ability to weight the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired;
 - iii. The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers;
 - iv. Procedures for the selection of subjects within the prison are fair to all prisoners and immune from arbitrary intervention by prison authorities or prisoners. Unless the principal investigator provides to the IRB justification in writing for following some other procedures, control subjects must be selected randomly from the group of available prisoners who meet the characteristics needed for that particular research project;
 - v. The information is presented in language which is understandable to the subject population;
 - vi. Adequate assurance exists that parole boards will not take into account a prisoner's participation in the research in making decisions regarding parole, and each prisoner is clearly informed in

advance that participation in the research will have no effect on his/her parole; and

- vii. Where the IRB finds there may be a need for follow-up examination or care of participants after the end of their participation, adequate provision has been made for such examination or care, taking into account the varying lengths of individual prisoners' sentences, and for informing participants of this fact.

4. Permitted research involving prisoners

Research must fall into one of the following categories:

- a. Study of the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects; [*Note that the definition of minimal risk for prisoner research at 45 CFR 46.303(d) differs from the definition of minimal risk for other research, contained in 45 CFR 46 subpart A, 45 CFR 46.102(i)*]
- b. Study of prisons as institutional structures or of prisoners as incarcerated persons, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects;
- c. Research on conditions particularly effecting prisoners as a class (for example, vaccine trials and other research on hepatitis which is much more prevalent in prisons than elsewhere; and research on social and psychological problems such as alcoholism, drug addiction, and sexual assaults) provided that the study may proceed only after the Secretary (through OHRP) has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice in the Federal Register of his intent to approve such research; or
- d. Research on practices, both innovative and accepted, which have the intent and reasonable probability of improving the health or well-being of the subject. In cases in which those studies require the assignment of prisoners in a manner consistent with protocols approved by the IRB to control groups which may not benefit from the research, the study may proceed only after the Secretary (through OHRP) has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice in the Federal Register of his intent to approve such research.

5. Previously enrolled subject becomes prisoner

When a previously enrolled research subject becomes a prisoner and the relevant research protocol was NOT reviewed and approved by the IRB in accordance with the requirements of HHS regulations at 45 CFR 46 subpart C, the principal investigator should promptly notify the IRB of this event. All research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated prisoner-subject must cease until the requirements of subpart C have been satisfied with respect to the relevant protocol.

NOTE: OHRP has allowed one important exception. In special circumstances in which the principal investigator asserts that it is in the best interests of the subject to remain in the research study while incarcerated, the IRB Chair may determine that the subject may continue to participate in the research until the requirements of subpart C are satisfied.

6. IRB review of previously enrolled subject circumstances
Upon receipt of notification that a previously enrolled research subject has become a prisoner, the IRB should promptly re-review the protocol in accordance with the requirements of subpart C if the principal investigator wishes to have the prisoner subject continue to participate in the research. The IRB will notify the investigator in writing that, except in the special circumstances noted above, all research interactions and interventions with, and obtaining identifiable private information about, the now-incarcerated prisoner-subject must cease until all of the requirements of subpart C have been satisfied with respect to the relevant protocol.

7. OHRP Review
Following receipt of the certification letter and research proposal, OHRP will determine if the proposed research meets any of the four categories of research permissible under HHS regulations at 45 CFR 46.306(a)(2). If OHRP determines that the research involves a category of research requiring Secretarial consultation with appropriate experts (see 45 CFR 46.306(a)(2)(iii) and (iv)), OHRP will notify the institution that the Secretary must consult with experts regarding the proposed research before a determination is made as to whether the research may involve a prisoner as a subject. When applicable, OHRP also will publish in the Federal Register a notice of intent to approve such research. HHS conducted or supported research involving writing to the institution on behalf of the Secretary under 45 CFR 46.306(a)(2) and informs the institution that the research involving the prisoner as a subject may proceed.

8. Record retention
All correspondence will be kept in the study files.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
013: REVIEW OF RESEARCH—ADDITIONAL PROTECTIONS FOR
CHILDREN**

I. PURPOSE

To document the policy and procedures used by the UTCOMC/EHS IRB regarding the review of clinical studies involving children.

II. SCOPE

This SOP applies to the IRB administrator, IRB members and investigators.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

IRBs are obligated to ensure that the rights and welfare of subjects are adequately protected. Children who are research subjects possess special vulnerabilities. These vulnerabilities relate to the increased susceptibility of children to harm (e.g., anxiety due to separation from parents or inexperience with medical procedures), as well as their limited or absent ability to make informed and voluntary decisions about research participation. Therefore, additional protections are afforded children as research subjects.

Research with children must satisfy the regulatory requirements of 45 CFR 46 Subpart D, "Additional Protections for Children Involved as Subjects in Research," and 21 CFR 50 Subpart D, "Additional Safeguards for Children in Clinical Investigations," as well as the general requirements of 45 CFR 46 Subpart A (the Common Rule). In addition to the requirements outlined in SOP 03 (Review of Research), the UTCOMC/EHS IRB shall determine that research with children satisfies the additional requirements outlined in Subpart D of the HHS and FDA regulations.

The latter regulations delineate permissible research based on three basic categories of risks and benefits:

1. Research involving no more than minimal risk;
2. Research involving more than minimal risk but offering the prospect of direct benefit; and

3. Research involving more than minimal risk without the prospect of direct benefit.

In addition, the investigator must usually obtain both the written permission of the parents or legally authorized representative (LAR) and the child's assent before the child may participate in the study. A child's mere failure to object is not assent. Federal regulations do not require that assent be sought from children starting at a particular age, but specify that assent should be sought when, in the judgment of the IRB, the children are capable of providing their assent, taking into account the age, maturity and psychological state of the children involved.

UT COMC/EHS IRB policy is that assent must be obtained from all children who are capable of providing assent as determined by the principal investigator or co-investigator. Thus, in addition to explaining the study to the parents, the investigator must explain the purpose, procedures, risks, benefits and voluntary nature of participation to the child in language that he/she can understand, and the child must affirmatively agree to participate.

The ultimate outcome of the process is agreement or disagreement by the minor to participate in the study. The intent of the assent process is undermined in situations where the option of dissent does not exist. Thus, it is disrespectful to the minor to initiate an assent process if the minor does not have a right to refuse to participate in the study. The researcher may judge the clinical situation to be such that an assent process should not be initiated. In such situations, the rationale for not initiating the assent process must be documented.

In accordance with:

45 CFR 46, Subpart D; 21 CFR 50 Subpart D; OHRP Guidance on Written IRB Procedures, 1/15/07.

OHRP Children's Special issues Page located at <http://www.hhs.gov/ohrp/children/>

OHRP Guidance on the Section 407 Review Process located at http://www.hhs.gov/ohrp/children/guidance_407process.html

OHRP FAQs on Research with Children located at <http://www.hhs.gov/ohrp/researchfaq.html>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

Definitions:

Assent: A child's affirmative agreement to participate in research. Mere failure to object, absent affirmative agreement, should not be construed as assent.

Children: Persons who have not attained the legal age for consent to treatment or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted.

Permission: The agreement of parent(s) or guardian to the participation of their child or ward in research.

Guardian: An individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care.

Minimal Risk: The probability and magnitude of harm or discomfort anticipated in the research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examination or tests.

IV. PROCEDURES

1. IRB composition
When reviewing clinical studies involving children that require full Board review, the UTCOMC/EHS IRB will have a pediatrician and/or other voting member who has expertise, experience and training in the care of children present when the study is discussed.
2. Categories of IRB review
When reviewing clinical studies involving children, the UTCOMC/EHS IRB will only approve research studies falling into one of the following categories:
 - a. Research not involving greater than minimal risk to the research participant (45 CFR 46.404; 21 CFR 50.51)
 - b. Research involving greater than minimal risk but presenting the prospect of direct benefit to the individual subject. Research in this category is approvable provided:
 - i. The risk is justified by the anticipated benefit to the subject; and

- ii. The relationship of risk to benefit is at least as favorable as any available alternative approach (45 CFR 46.405; 21 CFR 50.52).
- c. Research involving greater than minimal risks with no prospect of direct benefit to the individual subjects, but likely to yield generalizable knowledge about the subject's disorder or condition. Research in this category is approvable provided:
 - i. The risk represents a minor increase over minimal risk;
 - ii. The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social or educational situations; and
 - iii. The intervention or procedure is likely to yield generalizable knowledge about the subject's disorder or condition that is of vital importance for the understanding or amelioration of the subject's disorder or condition (45 CFR 46.406; 21 CFR 50.53).
- d. Research not otherwise approvable, but which presents an opportunity to understand, prevent, or alleviate serious problems effecting the health or welfare of children (45 CFR 46.407; 21 CFR 50.54). When a research study is approvable only under this category, the IRB will request additional review by a panel of experts convened by the Secretary of HHS or the Commissioner of the FDA. Final approval will be contingent upon a finding that the study is approvable by the expert panel in accord with 45 CFR 46.407 or 21 CFR 50.54.
- e. Children who are wards of the State or any other agency, institution, or entity can be included in research approved under (2c) or (2d) only if:
 - i. Such research is related to their status as wards; or
 - ii. The research is conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If research is approved under this section, the IRB shall require appointment of an advocate for each child who is a ward, in addition to any other individual acting on behalf of the child as guardian or in loco parentis. One individual may serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act

in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the investigator(s), or the guardian organization.

f. The category under which the study is approved will be appropriately documented in the minutes of the IRB meeting.

3. IRB approval of assent

The UTCOMC/EHS IRB will only approve studies that satisfy the following requirements for assent and permission:

a. Permission of one parent is sufficient for research approved under 2(a) and (b) above. For research approval under 2(c) and (d) above, permission of both parents/guardians is required, unless one parent is deceased, unknown, incompetent or not reasonably available, or when only one parent has legal responsibility for the care and custody of the child if consistent with State law (45 CFR 46.408(b); 21 CFR 50.55(e)(2)). UTCOMC/EHS IRB will require that each child provide assent, provided that the investigator determines that the child is capable of assent by evaluating the child's level of maturity, psychosocial and emotional capacity, as well as the nature of the study. The table below serves as a general guideline:

| Age (years) | Forms required | Way minor is addressed in the consent form | Who signs |
|-------------|----------------|--|--|
| 0-6 | Consent form | Your child | Parent signs consent |
| 8-11 | Consent form | Your child | Parent signs consent |
| | Assent form | You | Minor signs IF they understand what is happening |
| 12-17 | Consent form | Your child | Parent signs consent |
| | Assent form | You | Minor signs assent |

c. The assent of children is not necessary when it is determined that the child's capacity is so limited that consultation is not reasonable or where the intervention or procedure involved has a potential for direct benefit to the child's health and well-being, which is only available in the context of research.

d. Even if the child is capable of assenting, the IRB may waive the requirement under the same conditions for which consent may be waived under 45 CFR 46.116(d). The waiver conditions are not applicable, however, for

studies subject to FDA regulations for the protection of human subjects.

- e. If the IRB determines that a research protocol is designed for conditions or for a subject population for which parental or guardian permission is not reasonable (neglected or abused children), permission may be waived if an appropriate mechanism for protecting the children is substituted and the waiver is not inconsistent with local, state or federal laws.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
014: EXEMPTION FROM IRB REVIEW: DETERMINATION**

I. PURPOSE

To document the policy and procedures used by the UT COMC/EHS to review and evaluate submissions for exempt status.

II. SCOPE

This SOP applies to the IRB Chair or designee.

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members, investigators

III. BACKGROUND

Federal regulations provide for exemption from IRB oversight for certain kinds of research involving minimal risk. OHRP policy guidance requires that the determination that a study qualifies for exempt status be made by an entity other than the investigator. UTCOMC/EHS IRB policy requires that the determination of whether a study qualifies for exempt status be made by the Chair or other senior member of the IRB. This determination is made through submission and review of Exempt Request Form ([Form B](#)). Once a study has been determined to qualify for exempt status, no further oversight of the IRB is normally necessary. However, if revisions are made to the study as originally approved for exempt status, then the IRB must determine that the study remains eligible for exempt status.

In accordance with:

45 CFR 46.101(b), 45 CFR 46.102(d) and (f)

OHRP Guidance on Exemptions for Research on Public Benefit and Service Programs located at <http://www.hhs.gov/ohrp/humansubjects/guidance/exempt-pb.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURES

1. Exempt criteria
Unless otherwise required by department or agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories will be assigned the status of exempt from further oversight by the UT COMC/EHS IRB:
 - a. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as:
 - i. Research on regular and special education instructional strategies; or
 - ii. Research on the effectiveness of or the comparison among instructional techniques, curricular, or classroom management methods.
 - b. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:
 - i. Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and
 - ii. Any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of civil or criminal liability; or be damaging to the subjects' financial standing, employability or reputation.
 - c. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior that is not exempt under #2 if:
 - i. The human subjects are elected or appointed public officials or candidates for public office; or
 - ii. Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
 - d. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens if these sources are publicly available, or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.
 - e. Research and demonstration projects, which are conducted by or subject to the approval of the

- department or agency heads, and which are designed to study, evaluate or otherwise examine:
- i. Public benefit or service programs
 - ii. Procedures for obtaining benefits or services under those programs;
 - iii. Possible changes in or alternatives to those programs or procedures; or
 - iv. Possible changes in methods or levels of payment for benefits or services under those programs.
- f. Systematic investigations that do not involve research as defined at 45 CFR 46.102(d).
 - g. Research that does not involve "human subjects" as defined at 45 CFR 46.102(f).
2. IRB process
- Upon receipt of an Exempt Request Form (Form B) the IRB Administrator will:
- a. Affix date received stamp;
 - b. Assign IRB number;
 - c. Log into database;
 - d. Review [Form B](#) for IRB number and principal investigator's name.
3. The IRB administrator will prepare a packet for the IRB Chair to include:
- a. Correspondence concerning request;
 - b. Copy of the [Form B](#) application with associated documents.
4. The Chair or designee will review the documents and make a determination of exempt status on [Form B](#);
5. The IRB administrator or designee will prepare any correspondence for the investigator regarding the review and give to the Chair for review and signature.
6. After the correspondence is signed, the IRB administrator will make a copy of the correspondence for the exempt packet.
7. The original will be filed in the appropriate exempt packet. Exempt packets are filed sequentially in designated notebooks.
8. A copy with the reviewer's comments will be mailed to the investigator.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
015: IRB EXPEDITED REVIEW**

I. PURPOSE

To document the procedures used by the UTCOMC/EHS IRB to review and evaluate submission under expedited review.

II. SCOPE

This SOP applies to the IRB Chair, IRB administrator, Board members

Personnel Responsible:

UT COMC/EHS IRB Chair, administrator and Board members

III. BACKGROUND

The Department of Health and Human Services (HHS) and the Food and Drug Administration (FDA) have established and published in the Federal Register a list of categories of research that may be reviewed by the IRB through an expedited review procedure. The list will be amended, as appropriate, through periodic re-publication in the Federal Register.

Research activities with human subjects involving no more than minimal risk and involving one or more of the categories defined in the CFR may qualify for expedited review. In addition, minor changes in previously approved research during the period (of less than one year) for which approval is authorized may qualify for expedited review.

Activities listed should not be deemed to be of minimal risk simply because they are included on this list. Inclusion means that the activity is eligible for review through the expedited review procedure when the specific circumstances of the proposed research involve no more than minimum risk to human subjects. They apply regardless of the age of subjects, except as noted and pertain to both initial and continuing review.

Expedited Research Categories

- (1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met.

- a. Research on drugs for which an investigational new drug application (21CFR312) is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.)
 - b. Research on medical devices for which (i) an investigational device exemption application (21CFR812) is not required, or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.
- (2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows:
- a. From health nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or
 - b. From other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml/kg in an 8 week period and collection may not occur more frequently than 2 times per week.
- (3) Prospective collection of biological specimens for research purposes by noninvasive means. Examples:
- a. hair and nail clippings in a nondisfiguring manner;
 - b. Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;
 - c. Permanent teeth if routine patient care indicates a need for extraction;
 - d. Excreta and external secretions (including sweat);
 - e. Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue;
 - f. Placenta removed at delivery;
 - g. Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;
 - h. Supra- and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;
 - i. Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;
 - j. Sputum collected after saline mist nebulization.

- (4) Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. When medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.) Examples:
 - a. Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject's privacy;
 - b. Weighing or testing sensory acuity;
 - c. Magnetic resonance imaging;
 - d. Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, Doppler blood flow, and echocardiography;
 - e. Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.
- (5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis). (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects. 45CFR46.101(b)(4). This listing refers only to research that is not exempt.)
- (6) Collection of data from voice, video, digital, or image recordings made for research purposes.
- (7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies. (NOTE: Some research in this category may be exempt from the HHS regulations for the protection of human subjects 45CFR46.101(b)(2) and (b)(3). This listing refers only research that is not exempt.

- (8) Continuing review of research previously approved by the convened IRB as follows:
 - a. Where (i) the research is permanently closed to the enrollment of new subjects; (ii) all subjects have completed all research-related interventions; and (iii) the research remains active only for long-term follow-up of subjects; or
 - b. Where no subjects have been enrolled and no additional risks have been identified; or
 - c. Where the remaining research activities are limited to data analysis.

- (9) Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories 2-8 do not apply but the IRB has determined and documented at a convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Reviewers may exercise all the authority of the IRB except to disapprove the research. The reviewer may decide that the application does not meet expedited review requirements or that the application needs to undergo review by the full Board for other specific reasons.

The HHS and FDA may restrict, suspend, or terminate an institution's or IRB's use of the expedited review procedure when necessary to protect the rights or welfare of subjects.

In accordance with:

45 CFR 46.110; 21 CFR 56.110

OHRP Guidance on the Use of Expedited Review Procedures located at <http://www.hhs.gov/ohrp/humansubjects/guidance/exprev.htm>

Current Expedited Review Categories located at <http://www.hhs.gov/ohrp/humansubjects/guidance/expedited98.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURES

1. IRB review process
Upon receipt of a protocol for determination of expedited review, the following procedures will be utilized:
 - a. The IRB administrator will affix date-received stamp;

- b. The Initial Approval Form ([Form A](#)) is forwarded to the Chair or designee for determination of whether the application qualifies for expedited review;
 - c. If determined to be eligible for expedited review, the IRB administrator will assign an IRB number;
 - d. The Chair or designee is assigned the responsibility for reviewing the application;
 - e. The Chair or designee will review the application and consent documents according to applicable ethical principles and federal regulation.
2. Approval process
If the Chair or designee approves the application:
 - a. The results of the protocol review will be summarized in a letter to the principal investigator;
 - b. A copy of the correspondence will be placed in the IRB file;
 - c. The copy will be filed in appropriate study;
 - d. The original will be mailed to the investigator.
3. Expedited review denied
If it is decided that the research may not be expedited:
 - a. The investigator will be notified of the determination in writing;
 - b. The IRB administrator will make a copy of the correspondence for the IRB files;
 - c. The copy will be placed in the appropriate file for the study.
4. Revisions in previously approved expedited research
Revisions during the period of less than one year can qualify for expedited review. Such revisions include, but are not restricted to:
 - a. Amendments or modifications to a previously approved protocol/project
 - b. Descriptors that provide for a minor administrative or procedural change that does not alter or that decreases the risk to subject;
 - c. Minor amendments or revisions to a previously approved consent form;
 - d. Changes of the investigator who will conduct a previously approved (within one year) study, provided such individual has standing as a faculty member, resident or fellow and is otherwise qualified to conduct the study;
 - e. Non-English translations of informed consent documents submitted after initial approval.

5. The IRB administrator will prepare any correspondence for the investigator regarding the IRB's review and give to the Chair for review and signature.
6. The full Board will be advised of all expedited application approvals at the next regularly scheduled meeting.
7. Documentation of IRB review and approval will be included in IRB minutes.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
016: CONTINUING REVIEW OF RESEARCH**

I. PURPOSE

To document the procedures used by the UTCOMC/EHS IRB concerning continuing review and re-approval of research

II. SCOPE

This SOP applies to the IRB administrator, Board members

Personnel Responsible:

UT COMC/EHS IRB administrator and Board members

III. BACKGROUND

HHS and FDA regulations for the protection of human subjects require that IRBs create procedures for conducting continuing review of previously approved research and for reporting its findings to investigators and the institution. Continuing review must be substantive and meaningful. The IRB is responsible for determining that the criteria for initial approval of research studies are still satisfied at the time of continuing review. This process includes review of the risks of study participation, the potential benefits, the informed consent process and appropriate additional safeguards necessary to protect subjects. In particular, the IRB must determine whether any new information has emerged that would alter the acceptability of the risk-benefit ratio for the study, change the procedures necessary to protect the welfare of subjects, or necessitate revision of the informed consent disclosure. Reports regarding any unanticipated problems occurring since the last approval for the study are pertinent to these assessments.

Continuing review must be conducted at defined intervals appropriate to the degree of risk as determined by the IRB, but no less than annually. Continuing review cannot be performed under an expedited review procedure unless the original study was initially approved under expedited review criteria or the study satisfies other specific expedited review criteria (e.g., when no subjects have been enrolled and no new risks have been identified). Continuing review and approval is required for all studies reviewed by UT COMC/EHS IRB until a termination request has been granted.

If approval of a continuing review application is not received from the IRB prior to the expiration date of a study, then all research activities must stop. Enrollment of new subjects may not occur. In addition, interventions or interactions involving previously accrued subjects must cease, unless the IRB determines that it is in the best interests of individual subjects to continue participation. A request to continue research interventions or interactions with previously accrued subjects after the expiration date must be submitted in writing to the IRB, and it must include a list of the effected subjects and an explanation of why it is in their best interests to continue participation in the research interventions or activities. The principal investigator is advised in writing if the latter request is approved.

In accordance with:

45 CFR 46.103(b)(4) and (5); 45 CFR 46.108(b); 45 CFR 46.109(e); 45 CFR 46.111; 45 CFR 46.115(a); 21 CFR 56.108(1) and (b); 21 CFR 56.109(f)

OHRP Guidance on Written IRB Procedures, 7/15/07 located at <http://www.hhs.gov/ohrp/humansubjects/guidance/irbgd107.pdf>

OHRP Guidance on Continuing Review located at <http://www.hhs.gov/ohrp/humansubjects/guidance/contrev0107.pdf>

FDA Guidance on Continuing Review After Study Approval located at <http://www.fda.gov/oc/ohrt/irbs/review/html>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURES

1. Interval of review
The UTCOMC/EHS IRB shall conduct continuing review of research at intervals appropriate to the degree of risk, but not less than one calendar year. There is no provision for a lapse or grace period under federal regulations.
2. Date determination
The date by which continuing review must occur is determined by the date of the convened meeting at which the initial IRB approval was granted (even if approval was granted with administrative provisos). However, if continuing review and approval occurs within 30 days prior to the anniversary date on which approval expires, the IRB may retain the anniversary date in determining the next expiration date for the study (as

allowed by sponsor or initiating investigator). The expiration date of IRB approval will be documented in correspondence regarding the study.

3. **Form D**
Investigators must submit the request for continuing review utilizing the UTCOMC/EHS IRB Application to Continuing (Renewal) Review Form ([Form D](#)).
4. **Approval letter**
At the time of initial IRB approval, the letter of the UTCOMC/EHS IRB to the principal investigator will include the date on which approval of the study will expire and state that it is the responsibility of the principal investigator to initiate the request for continuation regardless of the time for which the activity has been approved by the sponsoring agency.
5. **Expedited continuation approval**
Continuation approval cannot be expedited unless the initial approval of the study satisfied criteria for expedited review, except in limited circumstances described in expedited review categories 8 and 9 at 63 FR 60364-60367, November 9, 1998. It is also possible that research activities that previously qualified for expedited review will have changed such that expedited review is no longer permitted for continuation approval.
 - a. **Category 8:** An expedited review procedure may be used for the continuing review of research previously approved by the convened IRB when:
 - i. The research is permanently closed to the enrollment of new subjects;
 - ii. All subjects have completed all research-related interventions and the research remains active only for long-term follow-up of subjects;
 - iii. No subjects have been enrolled and no additional risks have been identified; or
 - iv. The remaining research activities are limited to data analysis.
 - b. **Category 9:** An expedited review procedure may be used for the continuing review of research not conducted under an investigational new drug application (IND) or investigational device exemption (IDE) where categories (f2) through (8) do not apply but the IRB has determined and documented at a convened IRB meeting that the research involves no more than minimal risk and no additional risks have been identified.

6. IRB process
Upon receipt of the UTCOMC/EHS IRB Application to Continue (Renew) a Previously Approved Project ([Form D](#)), the IRB administrator will review the submission for completeness.
7. Review at convened meetings
Except when an expedited review procedure is used, the IRB will review continuation applications at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in a nonscientific area. Upon receipt of the complete continuing review form and attachments (current informed consent must be attached), the IRB administrator will place the request on the IRB agenda.
8. Materials for review
In conducting continuing review of research not eligible for expedited review, all IRB members will receive and review a protocol summary and a status report on the progress of the research that includes the following:
 - a. The number of subjects accrued;
 - b. A summary of any unanticipated problems and available information regarding adverse events (such a summary may be a simple statement that there have been no unanticipated problems and that adverse events have occurred at the expected frequency and level of severity as documented in the research protocol, the informed consent, document, and any investigator brochure);
 - c. A summary of any withdrawal of subjects since the last IRB review;
 - d. A summary of any complaints about the research since the last IRB review;
 - e. A summary of any recent literature that may be relevant to the research;
 - f. A summary of any amendments to the research since the last IRB review;
 - g. Any relevant multicenter trial reports;
 - h. Any other relevant information, especially information about risks associated with the research;
 - i. A copy of study monitor reports, if applicable; and
 - j. A copy of the current consent document and any proposed changes.
9. Administrator distribution
The IRB administrator will distribute a protocol summary, continuing review form and consent document (if there have been changes to the consent) to all Board members. In

addition, any IRB member may have access to the complete IRB file, protocol (including any modifications previously approved by the IRB) and relevant IRB minutes prior to the convened meeting.

10. Considerations examined
During the review, any of the following considerations may be examined:
 - a. Current status of the study with respect to whether enrollment remains open, the research remains active only for follow-up of current subjects, or remaining research activities are limited to data analysis;
 - b. The continuing review form and supporting documentation, including the current consent form;
 - c. Changes in the risk/benefit assessment based on factors such as:
 - i. Amendments or modifications in the research since the previous review;
 - ii. Recent reports in the literature relevant to the conduct of the research;
 - iii. Summary of adverse events or other unanticipated problems involving risks to subjects or others;
 - iv. Safety reports;
 - v. Changes in the Investigator Brochure;
 - vi. DSMB reports or reports from a similar monitoring body;
 - d. Consideration of protocol violations and/or deviations.
 - e. Incidences of investigator non-compliance;
 - f. Any complaints received from subjects;
 - g. Reports from employees, staff and faculty regarding problems with the study;
 - h. Management of protocols with lapsed approval;
 - i. IRB audit reports;
 - j. FDA or sponsor audits since last report;
 - k. Consideration of whether the monitoring plan remains adequate for the risk;
 - l. New conflict of interest information;
 - m. Evaluation of the current consent form in terms of accuracy and completeness, changes in the risk-benefit ratio, or the availability of new information that may affect the willingness of subjects to continue participation; and
 - n. Assessment of the continuing review period based on the materials presented at continuing review. The IRB will determine the continuing review period at the time of each continuing review.

11. Verification
UTCOMC/EHS IRB may require verification from sources other than the investigator that no material changes have occurred in the research since the previous IRB review.
12. Re-approval criteria
The criteria for re-approval at continuing review will be the same criteria used for the initial approval of research as specified at 45 CFR 46.111 and 21 CFR 56.111. Decisions to re-approve studies for less than one year will be based on factors including, but not limited to:
 - a. Unusual risks of harm;
 - b. Uncertainties in estimating the degree of risk; and
 - c. Special vulnerabilities of subjects that may require more frequent review to determine whether their rights and welfare are adequately protected.
13. IRB Vote
Based on its review of the information submitted at continuing review, the IRB will vote separately on each continuation application and take one of the following actions:
 - a. Approve the protocol for continuation;
 - b. Approve the protocol with administrative provisos;
 - c. Defer approval of the protocol pending resolution of substantive provisos; or
 - d. Terminate the protocol.
14. Chair or designee review
When reviewing research under an expedited review procedure, the IRB Chair or designee should receive and review all relevant documents as specified in #8, #9 and #10. Documentation of the results of continuing reviews conducted under an expedited review procedure must include:
 - a. The specific permissible categories per 63 FR 6030604-60367 justifying the expedited review; and
 - b. Documentation of the review and action taken by the IRB Chair or designee and any findings required under the HHS regulations.
15. New approval period (dates)
Upon re-approval, the IRB correspondence will include the new approval period (dates), the time for submission of the next continuing review, and any conditions of re-approval.
16. Failure to comply
If the investigator fails to comply with the UTCOMC/EHS IRB reporting requirements, the study will be considered in non-compliance and the IRB approval will automatically expire.

- a. Enrollment of new subjects cannot occur after the expiration of IRB approval;
 - b. Continuation of research interventions or interactions in previously enrolled subjects should only continue when the IRB finds it is in the best interests of the individual subjects to do so.
 - c. A request to continue research interventions or interactions with previously accrued subjects after the expiration date must be submitted in writing to the IRB, and it must include a list of the effected subjects and an explanation of why it is in their best interests to continue participation in the research interventions or activities. The principal investigator will be advised in writing if the latter request is approved.
 - d. With respect to expiration of IRB approval due to a failure to submit materials to the IRB prior to the expiration date, such expiration does not need to be reported to appropriate federal agency head as a suspension of IRB approval.
 - e. Suspension or termination of a protocol for reasons other than (e) will be reported to the appropriate federal agency head.
17. **Written correspondence**
Correspondence concerning any suspension or termination of IRB approval shall include a statement of the reason(s) for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, the sponsor and the appropriate federal agency department head within 48 hours.
18. **Minutes**
The minutes of the IRB should document separate deliberations, actions, and votes for each protocol undergoing continuing review by the convened IRB. A copy of all correspondence concerning continuing review will be kept in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
017: REPORTING UNANTICIPATED PROBLEMS INCLUDING
ADVERSE EVENTS**

I. PURPOSE

To specify the procedures for reporting unanticipated problems, including adverse events, which occur in studies approved by the UTCOMC/EHS IRB

II. SCOPE

This SOP applies to all investigators performing research approved by the UTCOMC/EHS IRB

Personnel Responsible:

UT COMC/EHS IRB administrator, Board members and investigators

III. BACKGROUND

The federal regulations for the protection of human subjects specify that institutions engaged in research with human subjects must have written procedures for ensuring prompt reporting to the IRB, institutional officials, and any supporting department or agency of any unanticipated problems, including adverse events, involving risks to subjects or others. Unanticipated problems, including adverse events, are considered reportable to the IRB when they involve occurrences that are unexpected, related to or possibly related to study activities, and significant enough to suggest that the research may place subjects or others at a greater risk of harm than was previously known or recognized. Adverse events, which involve untoward or unfavorable medical occurrences in human subjects, are the most common type of unanticipated problem reportable to IRBs. Serious adverse events (as defined below) if unexpected and related or possibly related to study procedures, are considered to be occurrences indicating that the research may involve greater risk of harm than previously known or recognized and, therefore, must be reported to the IRB.

While most unanticipated problems reported to the IRB involve adverse physical or psychological events that may be related to study interventions, other types of incidents, experiences or outcomes that occur during the conduct of human subjects research may also constitute unanticipated problems (e.g., social or economic

harm instead of the physical or psychological harm associated with adverse events). In other cases, unanticipated problems place subjects or others at increased risk of harm, but no harm occurs. These unanticipated problems may be reportable to the IRB even when they do not result in any actual harm to subjects. For example, unintended disclosure of confidential research data represents an unanticipated problem that is not an adverse event. Even if the breach of confidentiality does not result in harm to subjects, it may necessitate re-consideration by the IRB of the study procedures used to protect the confidentiality of the research data.

Reports of unanticipated problems are utilized by the IRB to determine whether the risk-benefit ratio for the study, study procedures and the previously approved informed consent process/document remain acceptable. In some cases, unanticipated problems warrant substantive changes to assure that the rights and welfare of subjects continue to be adequately protected. Changes that may be necessitated by unanticipated problems include, but are not limited to:

1. Modification of inclusion/exclusion criteria;
2. Implementation of additional monitoring procedures;
3. Suspension of enrollment of new subjects;
4. Suspension of research procedures in currently enrolled subjects;
5. Changes in procedures for protecting the confidentiality of research data;
6. Modification of consent documents to acknowledge newly identified risks; and
7. Provision of new risk information to previously enrolled subjects.

The procedures described below address only the obligations of investigators to report unanticipated problems, including adverse events, to the IRB. Investigators conducting FDA-regulated studies incur additional obligations for reporting adverse events to study sponsors. Similarly, study sponsors have obligations for informing local investigators regarding the occurrence of adverse events at other study sites. These additional obligations of investigators and sponsors involve more extensive adverse event reporting requirements than those specified by the IRB.

In accordance with:

45 CFR 46.103(b)(5); 21 CFR 56.108(b)(1); 21 CFR 312.53(c)(1)(vii); and 21 CFR 312.66.

OHRP Guidance on Reviewing and Reporting Unanticipated Problems Involving Risks to Subjects or Others and Adverse Events located at <http://222.hhs.gov/ohrp/policy/AdvEvtGuid.pdf>

FDA Draft Guidance for Clinical Investigators, Sponsors and IRBs on Adverse Event Reporting located at <http://www.fda.gov/OHRMS/DOCKETS/98fr/07d-0106-gd10001.pdf>

FDA Guidance on Continuing Review After Study Approval located at <http://www.fda.gov/oc/ohrt/irbs/review/html>

Definitions

Adverse event: Any undesirable or unintended (although not necessarily unexpected) medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom, or disease, temporally associated with the subject's participation in the research, whether or not considered related to the subject's participation in the research.

External adverse event: From the perspective of one particular institution engaged in a multicenter clinical trial, *external adverse events* are those adverse events experienced by subjects enrolled by investigators at other institutions engaged in the clinical trial.

Internal adverse event: From the perspective of one particular institution engaged in a multicenter clinical trial, *internal adverse events* are those adverse events experienced by subjects enrolled by the investigator(s) at that institution. In the context of a single-center clinical trial, all adverse events would be considered *internal adverse events*.

Possibly related to the research: There is a reasonable possibility that the adverse event, incident, experience or outcome may have been caused by the procedures involved in the research.

Serious adverse event: Any adverse event temporally associated with the subject's participation in research that meets any of the following criteria:

1. Results in death;
2. Is life-threatening (places the subject at immediate risk of death from the event as it occurred);
3. Requires in-patient hospitalization or prolongation of existing hospitalization;
4. Results in a persistent or significant disability/incapacity;
5. Results in a congenital anomaly/birth defect; or

6. Any other adverse event that, based upon appropriate medical judgment, may jeopardize the subject's health and may require medical or surgical intervention to prevent one of the other outcomes listed in this definition (examples of such events include allergic bronchospasm requiring intensive treatment in the emergency room or at home, blood imbalances or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse).

Unexpected adverse event: Any adverse event occurring in one or more subjects in a research protocol, the nature, severity, or frequency of which is not consistent with either:

1. The known or foreseeable risk of adverse events associated with the procedures involved in the research that are described in:
 - a. The protocol-related documents, such as the IRB-approved research protocol, any applicable investigator brochure, and the current IRB-approved informed consent document; and
 - b. Other relevant sources of information, such as product labeling and package inserts; or
2. The expected natural progression of any underlying disease, disorder, or condition of the subject(s) experiencing the adverse event and the subject's predisposing risk factor profile for the adverse event.

Unanticipated problem involving risks to subjects or others: Any incident, experience, or outcome that meets all of the following criteria:

1. Unexpected (in terms of nature, severity, or frequency) given:
 - a. The research procedures that are described in the protocol-related documents, such as the IRB-approved research protocol and informed consent document; and
 - b. The characteristics of the subject population being studied;
2. Related or possibly related to a subject's participation in the research; and
3. Suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) related to the research than was previously known or recognized.

IV. PROCEDURES

(Refer to [Appendix A](#) for reporting algorithm)

1. **Adverse Events**
For sponsor-supported or multi-center studies for which UTCOMC/EHS is not the primary sites, reports of problems occurring in research studies, including adverse events at internal or external sites, should be submitted only if they are determined by the principal investigator to be:
 - a. Unexpected;
 - b. Significant enough to suggest that subjects may be placed at greater risk of harm than previously known or recognized; and possibly, probably or clearly caused by the research intervention (rather than unrelated or unlikely related to the research intervention).Any serious adverse events, as defined above, if they are unexpected and related or possibly related to study procedures, must be reported to the IRB.

For investigator-initiated studies at UTCOMC/EHS, reports of problems occurring in research studies, including adverse events at internal or external sites, should be submitted even if they are expected and/or not related to study procedures.
2. **External adverse events**
For example, "IND Safety Reports" provided by the sponsor of the research, must be reported to the IRB within 10 working days of their receipt by the principal investigator.
3. **Internal adverse events**
Internal adverse events, other than deaths, must be reported by the principal investigator to the IRB within 5 working days of the time that the investigator or research administrator becomes aware of the occurrence.
4. **Deaths occurring locally**
Deaths occurring locally that are unexpected and are possibly, probably, or clearly caused by the research intervention must be reported by the principal investigator to the IRB within 48 hours of the time that the investigator or research staff member becomes aware of the occurrence.
5. **Unanticipated problems other than adverse events**
Must be reported by the principal investigator to the IRB within 5 working days of the time that the investigator or research staff member becomes aware of the occurrence.
6. **SAE [Form E](#)**
The Investigator will use the Significant Adverse Event (SAE) Reporting Form ([Form E](#)) to report adverse events.

- a. For local adverse events, the investigator should report:
 - i. The facts of the case, including subject identifier, adverse event or problem description;
 - ii. The event relationship to research interventions;
 - iii. The degree of seriousness;
 - iv. Whether the event was unexpected;
 - v. Date of injury;
 - vi. Whether the intervention was stopped, and if so, whether it was re-started; and
 - vii. When the event provides new risk information that alters the risk-benefit assessment and/or should be added to the informed consent disclosure.
 - b. For external adverse events, the investigator should submit information required on [Form E](#).
7. Protocol Waiver (also see Chapter 19, Protocol waivers and deviations)
- a. The local Investigator who receives a protocol waiver from a sponsor needs to submit the Protocol Waiver/Deviation & Violation Form ([Form I](#)) along with all supporting documentation.
 - b. The IRB administrator will review and assign it to either full Board or expedited review based on guidelines for continuing review.
 - c. Protocol waivers which present subject safety concerns or which reach the threshold of “changes in research activity” (due to recurrence for the same exclusion criteria) require IRB review and approval prior to implementation.
8. Protocol Deviation, [Form I](#)
- a. Deviations need to be reported to the IRB as a potential unanticipated problem involving risks to the subjects or others when they:
 - i. Increase risk or decrease benefit, effect the subject’s rights, safety, welfare, or effect the integrity of the resultant data;
 - ii. Have the potential to recur; or
 - iii. Were undertaken to eliminate an apparent immediate hazard to a research subject.
 - b. A local Investigator or other personnel who note a protocol deviation will submit the Protocol Waiver/Deviation & Violation Form ([Form I](#)) along with all supporting documentation.

- c. Likewise, when a sponsor requests that the IRB be notified of a deviation, it should be submitted with [Form I](#). The IRB administrator will review and assign it to either full Board or expedited review based on guidelines for continuing review.
 - d. Protocol deviations should be reported at the time of continuing review or sooner, as determined by the level of risk to the subject.
 - e. Recurring deviations may result in consideration of "Violation" by the IRB.
9. Violation
- a. Violations, as defined above, must be reported to the IRB. Such violations increase risk or decrease benefit, effect the subject's rights, safety, welfare, and/or the integrity of the resultant data, and should be reported to the subject and sponsor.
 - b. A local Investigator or other key personnel who note a violation will submit [Form I](#) along with all supporting documentation.
 - c. Likewise, when a sponsor requests that the IRB be notified of a violation, it should be submitted with [Form I](#). The IRB administrator will review all documents and assign it to full Board for review.
 - d. The investigator must submit violations to the IRB as soon as possible, but no later than 10 days after the violation occurs or the Investigator is made aware of the violation.
10. IRB authority
- The IRB has authority under HHS regulations at 45 CFR 46.109(a), to require, as a condition of continued approval, submission of more detailed information by the investigator, the sponsor, the study coordinating center, or data monitoring committee about any adverse event or other unanticipated problem occurring in a research protocol. Any proposed changes to a study in response to an unanticipated problem must be reviewed and approved by the IRB before being implemented, except when necessary to eliminate apparent immediate hazards to the subject.
11. Multicenter studies
- For multicenter studies, if the IRB proposes changes to the protocol or informed consent documents/process based on an adverse event report (in addition to any changes proposed by the study sponsor, coordinating center, or local investigator), the IRB will request that the local investigator discuss the proposed modifications with the study sponsor or coordinating

center and submit a response or necessary modifications for review by the IRB.

12. Local protocol changes
If internally occurring serious unanticipated problems necessitate changes in the study protocol or the informed consent process/document, then the IRB will notify the Human Protections Administrator.
13. Local suspension or termination
When internally occurring unanticipated problems require suspension or termination of a research study, they will be reported by the Human Protections Administrator to the supporting agency head (or designee) and OHRP.
14. All reportable adverse events will be placed on the agenda for review by the full Board.
15. The Investigator will be notified about whether the IRB considers the event reported to require a revision of the protocol, the informed consent document/process, or other aspect of the study, or about whether the IRB accepts any revisions proposed by the Principal investigator.
16. A copy of all correspondence/reports will be kept in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
018: REVIEW OF PROGRESS AND SAFETY REPORTS, OTHER THAN
REPORTS OF UNANTICIPATED PROBLEMS**

I. PURPOSE

To document requirements and procedures for submission of safety and progress reports for research studies, other than reports of unanticipated problems, to the IRB

II. SCOPE

This SOP applies to Board members, investigators and sponsors

Personnel Responsible:

Board members, investigators, and sponsors

III. BACKGROUND

HHS and FDA regulations for the protection of human subjects require that IRBs maintain procedures for continuing assessment of the acceptability of previously approved studies. This process includes review of the risks of study participation, the potential benefits, the informed consent process and appropriate additional safeguards necessary to protect subjects. In particular, the IRB must determine whether any new information has emerged that would alter the acceptability of the risk-benefit ratio for the study, change the procedures necessary to protect the welfare of subjects, or necessitate revision of the informed consent process/documents

Reports regarding the progress of research studies and the safety of research interventions, other than reports of unanticipated problems are pertinent to these assessments. Reports relevant to the safety of study interventions may be issued by a variety of entities, including the study sponsor, the data monitoring committee (DMC, sometimes referred to as a Data Safety Monitoring Board or DSMB), and the FDA. These reports include IND Safety Reports, FDA Safety Alerts and Public Health Advisories, MedWatch Reports and DMC reports on the safety of study interventions. Similarly, reports on the overall progress of research studies may be developed, including reports of interim analyses by the DMC and annual reports of the sponsor of the research.

It is important that the IRB review these various reports in a timely fashion to assure that its judgments regarding the acceptability of the risk/benefit ratio, the procedures necessary for protecting the welfare of subjects, and the adequacy of the consent documents process are based on complete, accurate and current information.

In accordance with:

45 CFR 46; 21 CFR 56

IV. PROCEDURES

1. Reports to be submitted
The PI shall forward all safety and progress reports supplied by the sponsor to the IRB within a reasonable period of time. Reports to be submitted include, but are not limited to:
 - a. FDA Safety Alerts;
 - b. FDA Public Health Advisories;
 - c. IND Safety Reports;
 - d. MedWatch Reports;
 - e. DMC reports;
 - f. Sponsor interim or annual reports.

2. PI Assessment
The principal investigator (PI) will review each report and provide the IRB with his or her assessment of whether any changes in the risk-benefit ratio for the study, study procedures, or the informed consent document/process are necessitated based on the report being submitted.

3. IRB process
Upon receipt of a progress or safety report, the administrator will stamp the date of receipt and forward the report and study file to the Chair or designee for review. Based on the review, a preliminary determination will be made whether the report requires a revision of the protocol, the informed consent document/process, or other aspect of the study, or suspension or termination of the study. If changes are determined to be necessary and represent more than minor revisions, then the changes must be reviewed and approved by the convened IRB.

4. IRB action
The IRB review of the submitted report may result in any of the following actions:
 - a. Stipulation of changes in study procedures and/or the informed consent document/process;
 - b. Suspension of some or all study-related procedures pending the completion of IRB review;

- c. Termination of IRB approval based on unacceptable changes in the risk-benefit ratio; or
 - d. Requirements for the investigator to submit additional information as deemed appropriate or necessary by the IRB.
5. The IRB will inform the investigator in writing of its review and any required modifications in the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
019: REPORTING PROTOCOL WAIVERS AND DEVIATIONS**

I. PURPOSE

To specify the procedures for the accurate and timely reporting of waivers and deviations from the requirements of approved research protocols to the UTCOMC/EHS IRB

II. SCOPE

This SOP applies to all personnel involved in the conduct of research approved by the UTCOMC/EHS IRB

Personnel Responsible:

IRB administrator, Board members and investigators

III. BACKGROUND

Federal regulations require that institutions develop written policies and procedures for prompt reporting of changes in research activities to the IRB. Protocol waivers and deviation represent unapproved changes in research activities and must be reported to the IRB. Reports of these changes in previously approved research studies are utilized by the IRB to determine whether the risk-benefit ratio for the study, study procedures and the previously approved informed consent process/document remain acceptable. In some cases, protocol waivers and deviations may warrant substantive changes to assure that the rights and welfare of subjects continue to be adequately protected. Changes that may be necessitated by protocol waivers and deviations include, but are not limited to:

1. Modification of inclusion/exclusion criteria;
2. Implementation of additional monitoring procedures;
3. Suspension of enrollment of new subjects;
4. Suspension of research procedures in currently enrolled subjects; and
5. Modification of consent documents to acknowledge revision of study procedures.

In accordance with:

45 CFR 46.103(b)(4)(iii); 21 CFR 56.108(a)(4)

Definitions

Note: *These are institutional definitions and may not match the investigator's or sponsor's definitions.*

Protocol waiver: Prospective approval by the research sponsor for the local investigator to accrue a subject who does not satisfy the approved inclusion/exclusion criteria for enrollment.

Protocol Deviation: Failure to follow procedures specified in the approved research protocol, in the absence of a protocol waiver.

Minor protocol deviation: Accidental or unintentional change(s) to the IRB approved protocol that (a) has no substantive effect on the risks or benefits for the individual research subject, and (b) has no substantive effect on the value of the data collected, and (c) does not result from willing or knowing misconduct on the part of an investigator or study staff.

Major protocol deviation: Change(s) to the IRB approved protocol that (a) has harmed or has posed a significant risk of substantive harm to the individual research subject, or (b) has compromised the scientific integrity of the data collected for the study, or (c) appears to result from the willing or knowing misconduct on the part of an investigator or study staff, or (d) appears to involve some other serious or continuing noncompliance with federal, state or local research regulations.

IV. PROCEDURES

1. Protocol waivers
 - a. When the local investigative site receives a protocol waiver from a sponsor, the Protocol Waiver/Deviation/Violation Form ([Form I](#)) including the details of the waiver, subject identification and all supporting sponsor documentation must be submitted to the UTCOMC/EHS IRB for review and approval. The IRB will acknowledge receipt of such waivers.
 - b. The waiver request will be forwarded to the IRB Chair or designee. If the IRB determines that there are relevant safety concerns or that the waiver is repetitive for the same exclusion criteria, then the IRB will notify the investigator that the waiver may not be implemented without further IRB review and approval.
 - c. Waivers which present concerns about subject safety or which could reasonably be considered as reaching the threshold of "revision in the research activity" (when repetitive for the same exclusion criteria) must not be

implemented without prior IRB review and approval as specified in 45 CFR 46.103(b)(4)(iii).

- d. If the IRB requires additional information, a letter will be sent to the investigator requesting the necessary information.
- e. All protocol waivers that may affect the safety of the subject or that might reasonably be considered to represent changes in the research activity will be reported to the full Board. A copy of the full report will be available to all Board member at the next convened meeting for review and action by the Board.
- f. If a protocol waiver might reasonably be considered to represent revision of the research activity, the IRB may require that the change be submitted as a request to revise the protocol.

2. Protocol deviations

- a. The principal investigator is responsible for reporting all protocol deviations occurring at the local research site to the IRB. All deviations should be reported as soon as possible, but no later than five working days after the investigator becomes aware of the event.
- b. The investigator will complete, sign and submit a protocol deviation report to the UTCOMC/EHS IRB using the Waiver/Deviation/Violation Form ([Form I](#)). Information must include:
 - i. The facts of the case;
 - ii. Subject identifier;
 - iii. Date of deviation;
 - iv. Impact on the subject's safety; and
 - v. A plan for preventing the deviation in the future (if applicable).
- c. If the IRB requires additional information, a letter will be sent to the investigator requesting additional information.
- d. All major protocol deviations will be reported to the full Board. A copy of the full report will be available to all Board members at the next convened meeting.
- e. The IRB will determine if additional actions or follow-up are required. Further action might include must is not limited to:
 - i. Stipulation of specific revisions in protocol procedures;
 - ii. Request for a corrective action plan from the principal investigator;
 - iii. Audit of investigator's study by the IRB;

- iv. Increasing the frequency of the continuing review period for the study; and
 - v. Suspension or termination of the study.
- f. A copy of all correspondence/reports will be kept in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
020: REVIEW OF ADVERTISEMENTS/SUBJECT RECRUITMENT
MATERIALS**

I. PURPOSE

To document the procedures for review of study advertisements and/or subject recruitment materials submitted to the UT COM/EHS Institutional Review Board

II. SCOPE

This SOP applies to all investigators and sponsors whose studies are reviewed and approved by the UT COMC/EHS IRB

Personnel Responsible:

IRB administrator, Board members and investigators

III. BACKGROUND

Under FDA regulatory guidance, advertising for research subjects is conceptualized a part of the informed consent and subject selection process. Advertisements and other recruitment materials refer to, but are not limited to:

1. Materials to be published in local newspapers;
2. Broadcast on television or radio networks;
3. Placed on the internet;
4. Posted or distributed in pamphlets, posters, signs, brochures, announcements, or promotional materials;
5. Descriptions of financial rewards, enrollment fees, and payment to subjects for participation; and
6. Any other plans, procedures or materials designed to solicit the participation of subjects in research.

The UTCOMC/EHSIRB reviews all advertisements and recruitment materials to ensure that the information provided to potential subjects accurately reflects the nature of the study and the procedures involved.

Generally, the FDA believes that any advertisement to recruit subjects should be limited to the information the prospective subjects need to determine their eligibility and interest. When appropriately worded, the following items may be included in advertisement, although inclusion of all items is not required:

1. The name and address of the clinical investigator and/or research facility;
2. The condition under study and/or the purpose of the research;
3. In summary form, the criteria that will be used to determine eligibility for the study;
4. A brief list of participation benefits, if any (e.g., a no-cost health examination);
5. The time or other commitment required of the subjects; and
6. The location of the research and the person or office to contact for further information.

FDA guidance on advertising and recruitment materials specifies that no claims should be made, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device. Such representation would not only be misleading to subjects, but would also be a violation of the FDA's regulations concerning the promotion of investigational drugs (21 CFR 312.7(a)) and of investigational devices (21 CFR 812.7(d)). In addition, advertising for recruitment into investigational drug, biologic or device studies should not use terms such as "new treatment," "new medication," or "new drug" without explaining that the test article is investigational. A phrase such as "receive new treatments" may cause study subjects to believe they will be receiving improved products of proven worth. Finally, advertisements should not promise "free medical treatment," when the intent is only to say subjects will not be charged for taking part in the investigation. Advertisements may state that subjects will be paid, but should not emphasize the payment or the amount to be paid, by such means as larger or bold type.

In accordance with:

FDA Guidance for Institutional Review Boards and Clinical Investigators on Recruiting Study Subjects located at <http://www.fda.gov/oc/ohrt/irbs/toc4.html-recruiting>.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Review of advertisements, [Form G](#) Requests for advertisements, solicitations, and/or recruitment materials ([Form G](#)) must be submitted to and approved by the IRB prior to use.

2. Guidelines for content

The content of advertisements, solicitations, and/or recruitment materials must observe the following guidelines:

- a. No claims should be made, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device.
- b. Advertising for recruitment into investigational drug, biologic or device studies should not use terms such as "new treatment," "new medication" or "new drug" without explaining that the test article is investigational. A phrase such as "receive new treatments" leads study subjects to believe they will be receiving newly improved products of proven worth.
- c. Advertisements should not promise "free medical treatment," when the intent is only to say subjects will not be charged for taking part in the investigation. Advertisements may state that subjects will be paid, but should not emphasize the payment or the amount to be paid, by such means as larger or bold type.
- d. When appropriately worded, the following items may be included in advertisements. It should be noted, however, that the FDA does not require the inclusion of all the listed items:
 - i. The name and address of the clinical investigator and/or research facility;
 - ii. The condition under study and/or the purpose of the research;
 - iii. In summary form, the criteria that will be used to determine eligibility for the study;
 - iv. A brief list of participation benefits, if any (e.g., a no-cost health examination);
 - v. The time or other commitment required of the subjects; and
 - vi. The location of the research and the person or office to contact for further information.
- e. Advertisements should not state, suggest or imply that all subjects will receive treatment for their condition if the study involves a placebo-control group.

3. Print materials

For print advertisements, a copy of the proposed printed materials must be submitted in its planned format along with a written plan of utilization, explanation of the type of media to be used and how monetary rewards are to be administered in order for the Board to review the layout of the advertisements as well as the content.

4. Multi-site studies
For large multi-site studies, the sponsor may provide a package of recruitment material to the sites for submission to the IRB for review and approval.
5. Radio, video, audio-taped and television
Advertisement scripts must also be first submitted to the UTCOMC/EHS IRB for approval
6. Ads in original submission
Advertisements provided in the original submission will be reviewed with the initial study submission. The IRB will notify the investigator of any revisions required in writing before approval can be granted.
7. Ads submitted after initial review
Advertisements submitted after the initial review may be reviewed by the IRB Chair or designee by expedited means. When the reviewer has doubts about the acceptability of the submission or when other complicating issues are involved, the materials will be reviewed at a convened meeting of the IRB. The IRB will notify the investigator of any revisions required in writing before approval can be granted.
8. Review of revisions
The UTCOMC/EHS IRB must review any revision(s) made to a previously approved advertisement that could affect its impact. These include content or media changes, as well as other changes such as images, pictures, font or size.
9. Students as participants
The IRB should exercise oversight with the use of students as participants in research. Specifically, the IRB should insure:
 - a. That consent for participation is sought only under circumstances which minimize the possibility of coercion or undue influence;
 - b. Which clearly identify methods used to maintain confidentiality; and
 - c. That genuinely equivalent alternatives to participation are available (e.g., term papers).
10. PI Notification
Following a decision by the IRB regarding the advertisement, the Investigator will be notified in writing of the decision.
11. Retention of records

A copy of all advertising/recruitment materials and IRB/investigator correspondence will be kept in the IRB files for the study.

NOTE: Any advertisement to be posted in the Erlanger Health System requires written permission from the marketing department.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
021: CONFLICTS OF INTEREST**

I. PURPOSE

To document the policy and procedures used the UTCOMC/EHS IRB to address conflicts of interest.

II. SCOPE

This SOP applies to the IRB administrator, Board members, investigators and all key research personnel.

Personnel Responsible

IRB administrator, Board members and investigators

III. BACKGROUND

Conflicts of interest exist when fulfillment of professional obligations may be undermined by personal or institutional interests. In the context of human research, investigators and IRB members have fundamental obligations to maintain integrity and objectivity of the scientific process, to preserve public trust, and to protect the rights and welfare of human subjects. Personal interests, particularly financial interests, may conflict with fulfillment of these professional obligations. In particular, financial conflicts of interest may affect the choice and approval of research projects, the manner in which subjects are recruited, the extent of risk to which subjects are exposed, and the interpretation of study results. Therefore, the IRB requires disclosure of potential or actual conflicts of interest to assure that investigators, key research personnel, and IRB members are able to meet their obligations to protect the rights and welfare of human subjects.

In addressing conflicts of interest, the IRB follows the University of Tennessee Health Science Center policy, "Conflicts of Interests: Research Related Issues," 4/10/06). According to this policy, potential conflicts of interest exist when persons have significant financial interests in the conduct of research activity.

Three types of significant financial interest are identified:

1. Payments from the research sponsor expected to exceed \$10,000 in the next twelve months;

2. Equity interests in the sponsor of the research; and
3. Intellectual property rights in the drug, device or other article being tested.

If investigators anticipate payments in excess of \$10,000 during the next twelve months from the sponsor of the research, have equity interests in excess of \$10,000 or have any intellectual property rights in the article, then they may not participate in the research. However, when investigators have equity interests of less than \$10,000 in the sponsor, then participation in the research is contingent on review and oversight by the University's Conflict of Interest Committee (COIC). Similarly if the sponsor is a commercial entity formed as a result of the investigator's entrepreneurial activities and the investigator has significant financial interests in that entity, the research is permissible with oversight by the COIC.

The IRB may consult the UTCOMC COIC to determine the appropriate way to manage an investigator's potential or actual conflicts of interest. Management strategies include but are not limited to:

- a. Disclosure of the conflict to prospective subjects;
- b. Modification of the research plan;
- c. Monitoring of the recruitment of subjects or the conduct of the research by independent reviewers; and
- d. Divestiture of the significant financial interests by the investigator.

In order to assure proper protection for the rights and welfare of human subjects, the IRB applies the same conflict of interest rules to its members with respect to their role in reviewing applications to conduct research. A member who has significant financial interests in a particular commercial entity may not participate in the review, deliberations or voting on studies supported by that sponsor. Members' conflict of interest disclosures are confirmed prior to each IRB meeting.

In accordance with:

45 CFR 46.107(e); 21 CFR 56.107(e); 45 CFR 46.109(b); 21 CFR 56.109(b), 45 CFR 46.111(a); 21 CFR 56.111(a).

HHS Guidance on Financial Relationships and Interests in Research With Human Subjects located at <http://www.hhs.gov/ohrp/humansubjects/finreltn/fguid.pdf>

Definitions

Significant financial interest: Anything of monetary value, including but not limited to:

1. Salary for services, or other payments from a single source (e.g., consulting fees or honoraria) when aggregated over the next twelve months are expected to exceed \$10,000;
2. Equity interests (e.g., stocks, stock options or other ownership interests); this includes gifted stock in a faculty/staff/student-owned company or a company proposing to sponsor research at the University; and
3. Intellectual property rights (e.g., patents, copyrights and royalties from such rights).

Financial interest includes the monetary interest of the employee, employee's spouse (whether or not they commingle assets) and the interest of the employee's dependent children

Sponsored programs: Research or other activities (including clinical trials) that are funded by sources external to the University

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Initial Approval Form ([Form A](#))
The UTCOMC/EHS IRB requires that investigators report potential financial conflicts of interest in the Initial Approval Form ([Form A](#)). The application must address the following considerations:
 - a. It must explain whether any key research personnel have a significant financial interest in the research activity as defined in the UTHSC policy dated 4/1/0/06. Key research personnel include the principal investigator, co-investigators, research coordinators, and any persons involved in securing the informed consent of prospective subjects.
 - b. Reportable financial interests include those of key research personnel, their spouses (whether or not they commingle assets) and the interests of their dependent children (including step- and foster children). In any given circumstance, the financial interests of key research personnel may also include the interests of non-dependent children and parents.
 - c. The application must indicate whether the UTCOMC/EHS Conflict of Interest Committee has formulated a plan for addressing any significant financial interests of key research personnel, and whether the UTCOMC Dean has

approved the plan. Documentation of the adopted plan and the approval must be attached to the application.

2. IRB review
The UTCOMC/EHS IRB will not approve a study application that includes key research personnel whose significant financial interests preclude participation in the study under the UTHSC Conflict of Interest policy.
3. Significant financial interest
If the investigator or other key research personnel has a significant financial interest that does not preclude participation in the research study under the UTHSC Conflict of Interest policy, then the IRB will not approve the study until the significant financial interests are reviewed by the UTCOMC/IRB Conflict of Interest Committee and a plan for managing those interests has been formulated by the Committee and UTCOMC Dean. However, the IRB retains the authority to reject the proposed plan for managing the conflict of interest as insufficient to assure proper protection for the rights and welfare of human subjects.
4. Managing COI
The IRB may require implementation of plans for managing significant financial interest that include, but are not limited to:
 - a. Disclosure of the significant financial interests to prospective subjects in the informed consent process;
 - b. Monitoring of research activities by independent reviewers;
 - c. Removal of the study personnel with significant financial interests from participation in the study; and
 - d. Divestiture of significant financial interests by study personnel.
5. IRB review of management plans
Plans for managing the significant financial interests of investigators and other key research personnel must be reviewed and approved by the full Board.
6. IRB member COI disclosure
Each IRB member shall attest to conflict of interest prior to each IRB meeting.
7. IRB member recusal
No IRB member may participate in the review, deliberation or voting for any study application if the member has a significant financial interest related to the test article or the

sponsor of the study. IRB administrative staff will review members' conflict of interest disclosures prior to the assignment of primary and secondary reviewers to assure that reviewers have no significant financial interests related to the study.

8. Record retention

A copy of any financial disclosure documents submitted by an investigator will be kept in the IRB files for the study. IRB members' conflict of interest disclosure forms will be maintained in the meeting files.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
022: SIGNIFICANT RISK/NONSIGNIFICANT RISK
DETERMINATIONS FOR MEDICAL DEVICE STUDIES**

I. PURPOSE

To document the policy and procedures for determination of significant risk/nonsignificant risk status for medical device studies.

II. SCOPE

This SOP applies to the IRB administrator, Board members.

Personnel Responsible

IRB administrator and Board members

III. BACKGROUND

Clinical investigations undertaken to develop safety and effectiveness data for medical devices must be conducted according to the requirements of the IDE regulations found in 21 CFR 812. The Investigational Device Exemption (IDE) regulations describe three types of device studies:

1. Significant risk (SR);
2. Nonsignificant risk (NSR);
3. Exempt studies.

The major differences between SR and NSR status relate to the IDE approval process and the sponsor's record-keeping and reporting requirements.

If SR status is assigned to the use of a device in a particular study, then the sponsor must have an approved IDE application before the study can proceed. In addition, the sponsor must observe extensive requirements for reporting to the FDA on the progress of the research and report IRB approval to the FDA.

If NSR status is assigned to a device study, then the sponsor may proceed without an approved IDE, must observe only abbreviated record-keeping requirements, and is not required to inform the FDA about the conduct of the study or IRB approval.

If a study is exempt from IDE regulations, then determination of risk status is not required.

Sponsors are responsible for making the initial risk determination and presenting it to the IRB. Unless the FDA has already made a risk determination for the study, the IRB must review the sponsor's SR or NSR determination for the proposed study and modify the determination if the IRB disagrees with the sponsor. If the FDA has already made the SR/NSR determination for the study, the determination of the FDA is final and must be communicated by the sponsor to the IRB.

If the sponsor identifies a study as NSR, the sponsor must provide the reviewing IRB an explanation of its determination (21 CFR 812.2(b)(ii)). The IRB may also use information from:

1. The application;
2. The protocol;
3. The investigator's brochure;
4. The package insert;
5. FDA Information Sheets;
6. Reports of prior investigations conducted with the device;
7. A description of subject selection criteria, monitoring procedures and other evaluations presented by the sponsor to categorize the device as SR or NSR.

If the IRB agrees with the NSR designation and a separate risk determination has not been made by the FDA, the study may proceed with IRB approval. If the IRB disagrees with a sponsor's classification of a device as NSR, then the investigation cannot proceed until the FDA has approved an IDE application and the IRB has approved the study under the regulations for the protection of human subjects.

In accordance with:

21 CFR 56; 21 CFR 812

FDA Guidance on Significant Risk and Nonsignificant Risk Medical Device Studies located at

<http://www.fda.gov/oc/ohrt/irbs/devrisk.pdf>

FDA Guidance on Frequently Asked Questions About Medical Devices located at <http://www.fda.gov/oc/ohrt/irbs/irbreview.pdf>

Definitions

NSR device: An investigational device that does not satisfy the definition of a SR device, i.e., a device that does not satisfy any of the conditions listed above that would qualify it as a SR device.

SR: An investigational device that:

1. Is intended as an implant and presents a potential for serious risk to the health, safety, or welfare of a subject; or
2. Is purported or represented to be for use supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of a subject; or
3. Is for a use of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health and presents a potential for serious risk to the health, safety, or welfare of a subject; or
4. Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

Unanticipated adverse device effect: Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Significant or nonsignificant risk
The IRB (or FDA) will determine whether the medical device is significant risk (SR) or nonsignificant risk (NSR) per 21 CFR 812 by use of any of the following:
 - a. A risk assessment report from the sponsor explaining the device classification;
 - b. An FDA letter approving the IDE (in which case the IRB will consider the investigation a SR device study);
 - c. A Pre-Market Approval letter; supplement letter, or amendment letter from the FDA;
 - d. Information from the study application, master protocol, investigator's brochure (or package insert) and other risk evaluations presented by the sponsor or investigator;
 - e. Review of the FDA Information Sheet containing examples of SR and NSR devices located at <http://www.fda.gov/oc/ohrt/irbs/devrisk.pdf>;
 - f. Reports of prior investigations conducted with the device;
 - g. Description of subject selection criteria;
 - h. Description of monitoring procedures;

- i. Potential harm that may be caused by any surgical procedure used to place or implant the device; and
 - j. The proposed use of the device and the nature of harm that may result from its use in the study.
2. SR -- full IRB review
All SR device studies are considered more than minimal risk and require full IRB review.
3. Significant risk requirements
If the IRB decides the study is significant risk, the IRB shall notify the investigator (in writing) that an IDE must be obtained from the FDA prior to IRB review of the study. Any amendments or corrections of deficiencies required by the FDA during the IDE process must be submitted for review and approval of the IRB. Once the IDE is obtained, the investigator may resubmit the study for IRB review.
4. FDA review of IDE
If an IDE application is or has been submitted to the FDA, but final approval has not been granted, the IRB can proceed with the review of the study, but final approval will not be granted until documentation of the FDA approval is submitted.
5. Non-significant Risk device studies
For NSR device studies, the IRB shall review the study per 21 CFR 56.111. If approved by the IRB, the investigator must comply with all abbreviated IDE requirements in 21 CFR 812.2(b), as well as informed consent and IRB regulations.
6. Minutes documentation
The IRB will record its determination of SR/NSR status in the minutes of the meeting. The minutes will describe the IRB's reasons for its SR or NSR determination and may also include the documents used to establish the IDE status for the study. For a SR determination, such documentation may include a copy of the IDE approval or conditional approval letter from the FDA. For a NSR determination, the documentation may include the FDA's NSR classification if the agency has made such a determination.
7. Unanticipated events
The IRB will review reports of unanticipated device events occurring during an investigation. Investigators are required to report these effects to the sponsor and to the IRB as soon as possible, but within ten working days after the investigator first learns of the effect. Should the IRB determine that the information gained in these reports changes the risk

assessment, the IRB can reconsider any NSR decision and/or require the modification of the informed consent to contain the new information.

8. Record retention
A copy of all correspondence will be kept in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
023: EMERGENCY USE**

I. PURPOSE

To document the policy and procedures for a submission regarding emergency use of a drug, biologic or device

II. SCOPE

This SOP applies to the IRB administrator, Board members, investigators and sponsor

Personnel Responsible

IRB administrator. Board members, investigators and sponsors

III. BACKGROUND

The FDA recognizes that situations arise in which an investigational drug, biologic or device may be used on an emergency basis in a manner inconsistent with an approved protocol, in the absence of an approved protocol, or by a physician who is not an investigator on a clinical study.

The FDA definition of the conditions under which emergency use is permissible involves two essential components:

1. The presence of a life-threatening situation in which no standard acceptable treatment is available; and
2. Insufficient time to secure prior IRB approval.

The emergency use provision is an exemption from prior IRB review and approval as specified at 21 CFR 56.104(c). While this exemption allows use of a test article in one subject without prospective IRB review, any subsequent use requires prospective review and approval.

Drug/Biologic: The emergency use of an unapproved investigational drug or biologic normally requires an existing IND. If medical circumstances require its use outside an approved protocol, the physician must contact the sponsor to determine if the drug or biologic can be made available for emergency use under the IND. The need for an investigational drug or biologic may also arise in an emergency situation that does not allow time for submission of an IND. In such a case, the FDA may authorize shipment of the test

article in advance of the IND submission. Requests for such authorization may be made by telephone or by other rapid communication method to the FDA.

Device: The FDA recognizes that emergencies arise where an unapproved device may offer the only possible life-saving alternative, but the device must be administered outside an approved IDE and/or protocol. Using its enforcement discretion, the FDA has not objected if a physician chooses to use an unapproved device in a situation that satisfies the conditions for permissible emergency use. The physician must subsequently provide documentation to the FDA that an emergency actually existed.

When emergency care is initiated without IRB review or approval, the patient may not be considered a research subject. Such emergency care may not be claimed as research, nor can the outcome be included in any report of a research activity.

In accordance with:

21 CFR 50(a)-(c); 21 CFR 56.102(d); 21 CFR 56.102(1); 21 CFR 56.104(c)

FDA Guidance on Emergency Use of an Investigational Drug or Biologic located at <http://www.fda.gov/oc/ohrt/irbs/drugsbiologics.html-emergency>

FDA Guidance on Emergency Use of Unapproved Medical Devices located at <http://www.fda.gov/oc/ohrt/irbs/devices.html-emergency>

Definitions

Emergency use: The use of an investigational drug or biological product with a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which there is not sufficient time to obtain IRB approval.

Life-threatening: Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, as well as diseases or conditions with potentially fatal outcomes. The criteria for a life-threatening disease or condition do not require the condition to be immediately life-threatening or to immediately result in death. Rather the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Severely debilitating: Diseases or conditions that cause major irreversible morbidity including blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

Test article: An unapproved investigational drug, biological or device for human use, including human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 or 354-360F of the Public Health Service Act.

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Full Board approval
Full Board approval is normally required for emergency use of a test article. If it is not feasible to convene a quorum before the treatment must be administered and the treatment will be administered in a UTCOMC/EHS facility, then the emergency use may proceed only if the IRB Chair and the EHS CEO or EHS Chief Medical Officer (who will notify the appropriate institutional officials, as appropriate) concur in its use. If the treatment will be administered in any other institution, emergency use may proceed without IRB approval only if the IRB Chair concurs and the investigator obtains institutional clearance or approval according to the institution's policies and procedures. IRB approval using an expedited review procedure is not allowed.
2. IRB approval or concurrence for emergency use of a drug or biologic will occur only if all of the following conditions are satisfied (specified at 21 CFR 56.102(d)):
 - a. The patient has a life-threatening condition requiring treatment before review at a convened meeting of the IRB is feasible;
 - b. There is no generally acceptable alternative treatment available; and
 - c. There is not sufficient time to submit a protocol/amendment to the IRB for approval.
3. IRB approval or concurrence for emergency use of a medical device will occur only if all of the following conditions are satisfied:
 - a. The patient is in a life-threatening condition that needs immediate treatment;

- b. There is no generally acceptable alternative treatment available; and
 - c. Because of the immediate need to use the device, there is no time to use existing procedures to secure FDA approval for use.
- 4. If approved
If the IRB approves or the Chair concurs with the emergency use, then:
 - a. The IRB Chair will notify the physician seeking emergency use approval or concurrence;
 - b. The IRB will use the date of concurrence to initiate tracking to ensure the investigator provides a report to the IRB within five days as required by 21 CFR 56.104.
- 5. Informed consent
For any emergency use, the investigator is required to obtain informed consent of the subject or the subject's legally authorized representative (LAR) unless both the investigator and a physician who is not otherwise participating in the clinical investigation certify in writing all of the following (21 CFR 50.23(a)):
 - a. The subject is confronted by a life-threatening situation necessitating the use of the test article;
 - b. Informed consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject;
 - c. Time is not sufficient to obtain consent from the subject's legally authorized representative; and
 - d. No alternative method of approved or generally recognized therapy is available that provides an equal or greater likelihood of saving the subject's life.
- 6. Use without IRB approval
If, in the investigator's opinion, immediate use of the test article is required to preserve the subject's life, and if time is not sufficient to obtain an independent physician's determination that the four conditions specified in (5) above apply, the clinical investigator should make the determination and have the determination reviewed and evaluated in writing by a physician who is not participating in the clinical investigation within five working days.

The investigator must submit written documentation regarding the decision to proceed without informed consent to the IRB within five working days after the use of the test article [21 CFR 50.23(c)].

7. **Post-Use reporting**
The investigator must provide a report on the use of the test article and the outcome for the patient to the IRB within five days as required by 21 CFR 56.104(c) and again at one month after use of the test article. All correspondence and documentation relevant to the use of the test article must be submitted to the IRB as soon as possible, but no later than five days after notification of the use.
8. **Sponsor requirements**
If the sponsor requires a written statement that the IRB is aware of the proposed use and considers the use to meet the requirements of 21 CFR 56.104(c) in order to approve shipment of the test article, the UTCOMC/EHS IRB will provide such correspondence upon request.
9. **Sponsor notification**
After emergency use of a medical device, the investigator must notify the sponsor of the emergency use if an IDE for the particular use exists. If an IDE does not exist, the investigator must notify the FDA of the emergency use and provide the FDA with a written summary of the conditions constituting the emergency, subject protection measures, and results. Copies of the correspondence should be submitted to the IRB.
10. **Full Board review**
If the emergency use of the test article has occurred without approval of the full Board, the Chair will review the documentation submitted and report to the full IRB at the next convened meeting after the documentation is received.
11. **IRB correspondence**
The IRB will include in its correspondence to the investigator/physician a statement indicating that any subsequent use of the test article at the institution requires prospective IRB review and approval.
12. **Record retention**
If the emergency use involves a test article utilized in an IRB-approved study, a copy of all correspondence and documentation concerning the emergency use will be kept in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
025: HUMANITARIAN USE DEVICES (HUD)**

I. PURPOSE

To document the policy and procedures for applications to utilize Humanitarian Use Devices.

II. SCOPE

This SOP applies to the IRB administrator, Board members, investigators and sponsor

Personnel Responsible

IRB administrator. Board members, investigators and sponsors

III. BACKGROUND

A humanitarian use device (HUD) is one that is intended to benefit patients by treating or diagnosing a disease or condition that effects fewer than 4,000 individuals in the United States in a calendar year. The FDA authorizes the marketing of HUDs through the issuance of a Humanitarian Device Exemption (HDE). HDEs are intended to encourage the discovery and use of devices intended for the treatment or diagnosis of diseases or conditions that afflict small numbers of individuals who would be left without satisfactory treatment options in the absence of the availability of such devices. HDEs accomplish this goal by allowing device manufacturers to market a HUD in the absence of scientifically valid clinical investigations demonstrating that the device is effective for its intended purpose. Rather, the manufacturer must only provide information indicating that:

1. The device will not expose patients to an unreasonable or significant risk;
2. The probable benefit to health outweighs the risks associated with its use; and
3. There is no comparable device available.

Although use of HUDs does not constitute research, FDA regulations governing their use require that the healthcare provider who will use an HUD obtain IRB approval before the HUD is used to treat or diagnose patients. The IRB is responsible for both initial and continuing review of the HUD use.

In conducting its initial review, the IRB must determine that use of the HUD will be consistent with the approved labeling for the device.

For continuing review, the IRB must follow the requirements at 21 CFR 56, but may use expedited review procedures unless it determines that full Board review should be performed. The IRB may also use its discretion in determining whether to approve the use of an HUD for a given period of time, for a specified number of patients, or on a case-by-case basis. However, the HUD regulations require that the use of the HUD be reviewed by the IRB no less frequently than once a year. After approval by the IRB, the regulations require that the healthcare provider transmit to the IRB any medical device reports related to the occurrence of adverse events that must be submitted to the FDA in compliance with the reporting requirements of 21 CFR 803.

The HUD regulations do not address informed consent requirements for the use of a HUD. However, local IRB policy and applicable law require the informed consent of patients who will receive a HUD. The informed consent disclosure must include:

1. Disclosure that the device is a HUD;
2. Disclosure that the effectiveness for the labeled indication has not been demonstrated;
3. A discussion of the potential benefits and risks of receiving the device and the availability of alternative treatments for the disease or condition.

Any clinical investigation of a HUD requires a separate IRB application and approval ([Form A](#)).

In accordance with:

21 CFR 50; 21 CFR 56; 21 CFR 803; 21 CFR 814, Subpart H

FDA Guidance on Humanitarian Device Exemption (HDE) Regulation: Questions and Answers, located at <http://www.fda.gov/cdrh/ode/guidance/1381.pdf>

FDA Guidance for IRBs, Clinical Investigators, and Sponsors: Frequently Asked Questions About Medical Devices, located at <http://www.fda.gov/oc/ohrt/irbs/irbreview.pdf>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Full Board review
Full Board review is required for any application to employ a humanitarian use device.

2. Required documents for review
Investigators must provide the following documents when submitting an application to use a HUD:
 - a. Initial Approval Form ([Form A](#))
 - b. FDA HDE letter authorizing marketing of the HDE;
 - c. The HUD manufacturer's product label, clinical brochure and/or other pertinent information regarding operation of the device;
 - d. A summary of safety and probable benefits from the device manufacturer;
 - e. A written statement from the applicant specifying that use of the HUD will be limited to the clinical indications listed in the FDA-approved product labeling;
 - f. Information describing the applicant's clinical experience with the device, any training completed or required, and a list of physicians who will be using the device;
 - g. Prior annual reports of the manufacturer regarding the use of the device;
 - h. An explanation of the costs that patients will incur with use of the device;
 - i. Medicare Coverage Analysis, as required; and
 - l. Any advertisements or other descriptive materials that might be used in marketing the HUD.

3. Informed consent
The informed consent of the patient or the patient's legally authorized representative (LAR) is required prior to the use of the HUD. The consent disclosure must contain the following items:
 - a. A description of the HDE/HUD approval process:

"Your medical care will involve the use of (specify device), which has been approved by the U.S. Food and Drug Administration (FDA) as a humanitarian use device (HUD). A HUD is a device used to diagnose or treat a disease or condition that affects fewer than 4,000 people in the United States each year. There is also no other device like the HUD that can treat this disease or condition. The FDA approves the clinical use of a HUD based on evidence that it does not pose a significant or unreasonable risk of injury for the patient. The FDA also believes that the potential benefit of the device to the health of the patient outweighs the risks of its use.

The FDA approval of a HUD is based on limited information about how effective this device is in humans.”

- b. A description of the HUD and how this device will be used in the clinical setting and why the patients are candidates for the use of this device;
 - c. A discussion of possible risks, side effects and/or adverse events associated with the HUD and its proposed clinical use;
 - d. A discussion of the possible benefits associated with the clinical use of the HUD;
 - e. A discussion of any alternative treatments or procedures that the patient may wish to consider in lieu of the clinical application of the HUD; and
 - f. A statement that consent to receive the device is voluntary and a description of the procedures to be followed if the patient decides to discontinue use of the device.
4. IRB determination of limitations
At the time of initial review, the IRB will determine whether any further limitations will be placed on the use of the device beyond those specified in the approved labeling, such as use according to a specific protocol. However, any use inconsistent with the FDA-approved labeling is not permitted.
5. Continuing review
Applicants will be required to submit a continuing review report as determined by the IRB, but at least annually. This report will include information describing the applicant's clinical experience(s) with the device.
6. Additional submissions
The healthcare provider must also submit the following items to the IRB on a timely basis:
- a. Any amendments or supplements to the HDE;
 - b. Annual reports from the HDE holder;
 - c. Any reports of adverse effects or device failures submitted to the FDA as required under 21 CFR 803;
 - d. Any results of further animal, laboratory or clinical testing that may effect the risk-benefit ratio for use of the device;
 - e. Any final report from the IDE sponsor; and
 - f. A final report from the applicant.
7. HUD off-label use

If the HUD is used in an emergency situation (off label) to save the life or protect the physical well-being of a patient, the procedures outlined in FDA regulations and local IRB policy must be followed as specified in SOP #23.

8. HUD emergency procedures
If the HUD is employed for compassionate use, the procedures outlined in FDA regulations and local IRB policy must be followed as specified in SOP #23.
9. Record retention
All documentation regarding review and approval of the use of the HUD will be maintained in a separate file according to the same record keeping requirements as for research studies.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
026: CERTIFICATES OF CONFIDENTIALITY**

I. PURPOSE

To document the policy and procedures concerning certificates of confidentiality (COC).

II. SCOPE

This SOP applies to all studies approved by the UTCOMC/EHS IRB.

Personnel Responsible

IRB administrator and Board members

III. BACKGROUND

Under the Public Health Service Act 301(d), 42 USC 241(d), the Secretary of the Department of Health and Human Services (HHS) may authorize persons engaged in biomedical, behavioral, clinical or other research to protect the privacy of individuals who are the subject of such research by withholding from all persons not connected with the conduct of such research the names or other identifying characteristics of such individuals. The privacy of the research subjects referred to in 301(d) is protected through the issuance of Certificates of Confidentiality. Persons authorized under a COC to protect the privacy of such individuals may not be compelled in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings to identify such individuals. By protecting researchers and institutions from being compelled to disclose information that would identify research subjects, COCs help to minimize risks to subjects by adding an additional layer of protection regarding confidentiality.

The protection afforded by COCs is not limited to federally supported research. Researchers may obtain COCs provided that a determination is made that the research is of such a sensitive nature that protection is necessary to perform the research. Certificates are issued by the National Institutes of Health (NIH) and other HHS agencies.

HHS has determined that research may be considered sensitive if it involves the collection of any of the following types of information:

1. Information related to sexual attitudes, preferences, or practices;
2. Information related to the use of alcohol, drugs, or other addictive substances;
3. Information pertaining to illegal conduct;
4. Information that, if released, could reasonably be damaging to an individual's financial standing, employability, or reputation in the community;
5. Information that would normally be recorded in the patient's medical record, and the disclosure of which could reasonably lead to social stigmatization or discrimination;
6. Information pertaining to psychological well-being or mental health;
7. Genetic information.

Other federal agencies may evaluate applications for COC using different criteria.

COCs protect subjects from compelled disclosure of identifying information but do not prevent the voluntary disclosure of identifying characteristics of research subjects. Researchers, therefore, are not prevented from voluntarily disclosing certain information about research subjects, such as evidence of child abuse or a subject's threatened violence to self or others. If a researcher intends to make such voluntary disclosures, the consent form should clearly indicate the specific limitations on the protection of confidential information. Furthermore, COCs do not prevent other types of intentional or unintentional breaches of confidentiality. As a result, investigators and IRBs must ensure that other appropriate mechanisms and procedures are in place to protect the confidentiality of the identifiable private information to be obtained in the proposed research.

In accordance with:

Public Health Service Act 301(d), 42 U.S.C. 241(d).

OHRP Guidance on Certificates of Confidentiality (2003) located at <http://www.hhs.gov/ohrp/humansubjects/guidance/certconf.pdf>

For more information on Certificates of Confidentiality and their limitations, see <http://grants.nih.gov/grants/policy/coc/index/htm>

For Certificate of Confidentiality contacts at the NIH, see <http://grants.nih.gov/grants/policy/coc/contacts.htm>

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Obtaining a Certificate of Confidentiality
Investigators may voluntarily seek, or the UTCOMC/EHS IRB may require an investigator to obtain, a DHHS COC for research of a sensitive nature.
 - a. Applications must be made for each specific protocol. OHRP's website contains a list of contacts for different federal agencies concerning COCs located at <http://www.hhs.gov/ohrp/humansubjects/guidance/certconf.pdf>.
 - b. COCs are not transferable from one protocol to another.
 - c. COCs are effective the date issued; investigators must obtain an extension if the COC will expire prior to study completion.
 - d. If a researcher intends to make voluntary disclosures of confidential information, the consent form should clearly indicate the specific limitations that will be placed on the protection of confidentiality.
2. If the UTCOMC/EHS IRB determines that a Certificate of Confidentiality is necessary to minimize risks to human subjects, the final approval of the study will not be granted until the COC is obtained.
3. A copy of any COC and/or any amendments to such an application must be submitted to the UTCOMC/EHS IRB.
4. Any COC or correspondence regarding it will be maintained with the study files.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
027: RESPONSIBILITIES OF INVESTIGATORS**

I. PURPOSE

To document the responsibilities of investigators who submit study applications to the UT COMC/EHS IRB

II. SCOPE

This SOP applies to all investigators.

Personnel Responsible

IRB administrator, Board members and investigators

III. BACKGROUND

Protection of the rights and welfare of human subjects is achieved through a framework of comprehensive rules and regulations, independent oversight of research activities by IRBs and other responsible agencies, and the moral integrity and conscientiousness of individual investigators.

In submitting a new study application for review and approval by the IRB, the principal investigator agrees to assume important responsibilities related to the protection of human subjects. These obligations involve:

1. Adhering to the approved protocol;
2. Securing and documenting informed consent;
3. Obtaining prior IRB approval for revisions;
4. Reporting on the progress of the research in a timely fashion;
5. Notifying the IRB regarding unanticipated problems and serious or continuing noncompliance with regulations and policies;
6. Reporting on the completion of the study;
7. Maintaining complete study records;
8. Supervising all key research personnel and assuring their basic training in the protection of human subjects;
9. Disclosing potential conflicts of interest; and
10. Permitting inspection of all study records.

In order to fulfill these obligations, investigators must execute them in accord with applicable law, regulations, and local IRB policies and procedures. Because investigators and other key research personnel

are the individuals who interact directly with human subjects, their fulfillment of these obligations is crucial to effective protection for the rights and welfare of human subjects.

In accordance with:

45 CFR 46; 21 CFR 50, 56

OHRP Investigator Responsibilities Frequently Asked Questions, located at <http://www.hhs.gov/ohrp/investigatefaq.html>

FDA Draft Guidance for Industry: Protecting the Rights, Safety, and Welfare of Study Subjects—Supervisory Responsibilities of Investigators, located at <http://www.fda.gov/OHRMS/DOCKETS/98fr/07d-0173-gd10001.pdf>

[FDA Guidance for Industry: Investigator Responsibilities—Protecting the Rights, Safety, and Welfare of Study Subjects](#)

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. Responsibility agreement
Principal investigators must include in their initial study application to the UTCOMC/EHS IRB a signed statement that they agree to assume the following responsibilities:
 - a. I certify that the information provided in this application is complete and correct to the best of my knowledge.
 - b. I accept ultimate responsibility for the conduct of this study, the ethical performance of the project, and the protection of the rights and welfare of the human subjects who are directly or indirectly involved in this project.
 - c. I will comply with all policies and guidelines of the UTCOMC and affiliated institutions where this study will be conducted as well as with all applicable federal, state and local laws regarding the protection of human subjects in research.
 - d. I understand that any false, fictitious or fraudulent statement or claims may result in criminal, civil or administrative penalties.
 - e. I will ensure that personnel performing this study are qualified, appropriately trained and will adhere to the provisions of the IRB-approved protocol.

- f. I will not modify this IRB-approved protocol or any attached materials without first obtaining IRB approval for an amendment to the previously approved protocol.
 - g. I assure that the protected health information requested, if any, is the minimum necessary to meet the research objectives.
 - h. I assure that the protected health information I obtain, if any as part of this research will not be reused or disclosed to any parties other than those described in the IRB-approved protocol, except as required by law.
 - i. I assure that adequate resources to protect participants (i.e., personnel, funding, time, equipment and space) are in place *before* implementing the research project, and that the research will *stop* if adequate resources become unavailable.
2. Knowledge of relevant policies and procedures
In order to adequately fulfill these obligations, investigators and other key research personnel must observe federal regulations, guidance, and local IRB policies and procedures that relate to their implementation. Lack of knowledge regarding relevant policies and procedures does not excuse failure to meet these obligations.
3. IRB authority to suspend investigator privilege
The IRB has the authority to suspend or terminate the privilege of investigators to conduct a study due to any instance of serious or continuing noncompliance with the obligations stated above and the policies and procedures for their implementation.
4. Record retention
A copy of the signed statement of investigators and all communications regarding their fulfillment of these obligations will be maintained in the IRB file for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
028: APPEAL OF IRB DECISIONS**

I. PURPOSE

To document the procedures for appeals regarding IRB decisions.

II. SCOPE

This SOP applies to all investigators performing research under the auspices of the UTCOMC and EHS and its affiliated institutions.

Personnel Responsible

IRB administrator, Board members and investigators

III. BACKGROUND

Under federal regulations for the protection of human subjects, applications to conduct research studies may not be implemented without prior approval of the IRB under whose auspices the research will occur. Moreover, officials of the institution(s) in which the proposed might occur may not approve research if it has been disapproved by the IRB. Applications that are reviewed on an expedited basis by the Chairperson or designee may not be disapproved without review by the convened IRB. If the full Board disapproves a new application to conduct research, an application to continue a previously approved project, or a revision application, investigators may file an appeal requesting that the Board reconsider its action. This process is available to all investigators by written request.

In accordance with:

45CFR46, 21CFR 56

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects

IV. PROCEDURES

1. If the convened IRB disapproves a new application to conduct research, an application to continue a previously approved

project, or a revision application, the letter of notification to the investigator will include a statement of the reason(s) for the Board's decision.

2. The investigator may submit a written response to the action taken by the convened committee. The response must provide adequate reasons for asking the IRB to reconsider its action.
3. At the request of the investigator and with the acquiescence of the Chairperson, the investigator may also present his/her response to the convened Board.
4. The Board will review the response of the investigator and determine whether to uphold or vacate its original action. The results of the Board's deliberation and voting will be conveyed to the investigator.
5. The Board's decision on the appeal is final and no further appeal is permitted.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
029: INVESTIGATOR NON-COMPLIANCE**

I. PURPOSE

To provide a procedure for addressing issues of investigator noncompliance reported to the UTCOMC/EHS Institutional Review Board.

II. SCOPE

This SOP applies to all investigators and other research personnel involved in studies review by the UTCOMC/EHS IRB

Personnel Responsible

IRB administrator, staff, and Board members

III. BACKGROUND

The IRB has the authority to place research activities on hold, as well as to suspend or terminate approval of research that is not being conducted in accordance with the IRB policies or federal regulations for the protection of human subjects. Federal regulations require that institutions develop written policies and procedures for handling complaints and/or reports of noncompliance with the regulations or the policies of the IRB.

Under federal regulations at 45CFR46.103(b)(5) and 21CFR56.108(b), IRBs must also have written procedures for promptly reporting to appropriate institutional officials and agency heads any serious or continuing noncompliance of investigators with federal regulations and local IRB policy, and any suspension or termination of research studies resulting from noncompliance.

In accordance with:

45CFR46.103(b)(5); 45CFR46.113; 21CFR56.108(b)

OHRP Guidance on Reporting Incidences at
http://www.hhs.gov/ohrp/policy/procedures_for_reporting_052505.pdf

Definitions

Noncompliance: Violation of federal regulations or local IRB policies or determinations regarding protection for the rights and welfare of human subjects

Temporary hold: Discontinuation of previously approved research, directed by the IRB, pending further investigation of alleged instances of noncompliance and/or implementation of minor corrective action

Suspension: Discontinuation of previously approved research, directed by the IRB, following determination of instances of serious noncompliance, and pending formulation and implementation of substantial corrective action

Termination: Closure of previously approved research, directed by the IRB, following determination of instances of serious noncompliance for which implementation of corrective action is not appropriate.

IV. PROCEDURES

1. Upon receipt of a complaint or allegation of noncompliance the IRB Administrator/designee will send a copy of the report to the Chair. The possible types of complaints covered under this policy include, but are not limited to, the following:
 - a. Verbal or written complaints from subjects in research;
 - b. Reports of protocol noncompliance (including information from monitoring letters or sponsor correspondence);
 - c. Failure of the investigator to file reports required by the IRB;
 - d. Publications written by investigators without IRB approval of the referenced study; and
 - e. FDA or local IRB audits or reports regarding an investigator or a study.
2. The report will be reviewed by the IRB Chair. The Chair and/or designee may consult with IRB administrative staff, IRB members and other knowledgeable consultants in reviewing the report.
3. The IRB Chair/designee will determine whether a temporary hold on research activities is required to protect the rights and welfare of subjects until the complaint/report is investigated

and resolved. If a temporary hold is necessary, the PI will be notified within 48 hours of the determination.

4. Additional information regarding the report may be obtained by the IRB Chair and/or designee including, but not limited to, the following:
 - a. Interview or written inquiry to the author(s) of the complaint/report;
 - b. Interview or written inquiry directed to the PI or other study personnel;
 - c. Request for relevant research records from the PI or study personnel;
 - d. IRB audit of the study; and
 - e. Other information as needed.
5. The IRB Chair/designee may determine that a compliance audit is merited. If so, the audit will be conducted in a timely manner according to the SOP or IRB audits of research studies.
6. If minor problems permitting corrective action are identified, the IRB Chair and/or designee will communicate with the PI regarding the nature of the problems and request the formulation of appropriate corrective actions. If appropriate corrective actions are implemented, then the matter will be considered resolved and any temporary hold on the research will be lifted.
7. If serious problems meriting suspension of the study are identified by the IRB Chair, then the following individuals will be notified in writing with 48 hours of the determination:
 - Principal investigator;
 - Chair or Division Chief;
 - Sponsor;
 - Vice Chancellor for Research;
 - Appropriate federal dept or agency head.
8. The nature of the problem and the corrective plan formulated by the investigator will be reviewed by the full Board at the next convened meeting. If the Board accepts the corrective action plan and appropriate corrective actions are implemented, then the suspension will be lifted and the previously enumerated officials will be notified in writing within 48 hours of the determination that the corrective actions have been implemented. If the Board determines that there are deficiencies in the response of the investigator requiring

continuation of the suspension, then the following individuals will be notified in writing within 48 hours of the Board's determination:

- Principal investigator
- Chair or Division Chief;
- Sponsor;
- Vice Chancellor for Research; and
- Appropriate federal department or agency head.

The basis for the continuing suspension will be clearly delineated in these communications. The Chair and/or designee will communicate with the PI regarding the continuing nature of the problems and request the formulation of appropriate corrective actions.

9. If serious problems meriting termination of the study are identified, then the nature of the problem will be reviewed with the full Board at the next convened meeting. If the Board approves termination of the study, then the following individuals will be notified in writing within 48 hours of the Board's determination:

- Principal investigator
- Chair or Division Chief;
- Sponsor;
- Vice Chancellor for Research; and
- Appropriate federal department or agency head.

The basis for the termination will be clearly delineated in these communications.

10. When problems are identified meriting suspension of a study, potential corrective actions that the Board may encores include, but are not limited to, any of the following:

- a. Requiring changes in study procedures or the informed consent process or disclosure;
- b. Directing the investigator to destroy or surrender data and/or specimens gathered from previously accrued subjects;
- c. Requiring more frequent continuing review of the study;
- d. Scheduling for-cause audits of the research study;
- e. Requiring that the research activity and/or informed consent process be monitored by an individual designated by the IRB;
- f. Requiring that the investigator inform previously accrued subjects regarding the identified elements of noncompliance; and

- g. Suspension or termination of other research studies conducted by the PI.
- 11. Communications from the PI, FDA, OHRP, sponsor or other involved persons regarding the suspension or termination of previously approved studies will be carefully evaluated by the IRB Chair and reviewed with the full Board in determining appropriate responses to instances of noncompliance.
- 12. A copy of all correspondence/reports will be maintained in the IRB files for the study.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
030: AUDITING OF RESEARCH STUDIES**

I. PURPOSE

To document the policy and procedures used by the UTCOMC/EHS IRB regarding the auditing of IRB-approved studies.

II. SCOPE

This SOP applies to the IRB administrator, IRB members, compliance auditing staff, and investigators

Personnel Responsible

IRB administrator and compliance auditing staff

III. BACKGROUND

Under federal regulations for the protection of human subjects, IRBs must maintain written procedures for ensuring prompt reporting of any unanticipated problems involving risks to subjects or others, or any serious and continuing noncompliance with federal regulations or local IRB policies and procedures. In addition, the regulations require IRBs to conduct continuing review of previously approved research, and specifically authorize IRBs to observe or have a third party observe, the consent process and the research as part of the continuing review process.

One component of the IRB's compliance oversight activities involves auditing of previously approved studies. The process of compliance auditing is meant to accomplish several important purposes:

1. To assure that human subjects are properly protected, and that the procedures used to accomplish this goal are carefully documented;
2. To assist investigators in complying with the current regulatory standards for protecting human subjects and avoid any external sanctions that may result from noncompliance with the standard of practice;
3. To assure that the University and affiliated institutions remain in good standing with federal agencies having oversight of human subjects research activities.

In accordance with:

45 CFR 46.103(b)(5); 45 CFR 46.109(e); 21 CFR 56.108(b); 21 CFR 56.109(f)

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. The UTCOMC/EHS IRB will have the authority or may designate a third party to observe the conduct of any research activity, and may review at any time all research records, including but not limited to:
 - a. Informed consent documents;
 - b. Regulatory files;
 - c. IRB files;
 - d. Subjects' research and medical records;
 - e. Clinical materials;
 - f. Record storage;
 - g. Computer files; and
 - h. Results of procedures and tests performed during the course of the research.
2. Research compliance auditing staff will also have the authority to observe the informed consent process, and to interview subjects either during or after their participation in research activities.
3. The IRB research compliance auditor, at the direction of the Chair, will schedule audits of previously approved research studies.
4. Criteria for choosing studies for audit include, but are not limited to:
 - a. Random selection;
 - b. Sufficient cause as determined by the IRB;
 - c. High risk studies as designated by the Board;
 - d. Any report of suspected noncompliance;
 - e. Research terminated by the IRB due to failure by the investigator to submit the study for continuing review or failure to respond to a request for information from the IRB;
 - f. Verification of continuing review reports; and
 - g. Studies reporting a large number of unanticipated problems, including adverse events, including adverse events and/or protocol deviations.

5. Prior to initiation of an audit, the investigator will be notified by the compliance auditor by fax, email, or certified mail. An acceptable date and time will be determined for the audit.
6. The UTCOMC audit form will be used and may be amended to capture all required information.
7. Audit review may include but are not limited to:
 - a. Any study/research-related documents and source documents, such as medical records;
 - b. Specimens and associated collection processes
 - c. Test article documentation and storage; and
 - d. Computer hardware and/or software associated with the research.
8. The principal investigator will be requested to provide a list of all study participants to the auditor.
 - a. If the number of subjects enrolled is large, the auditor may select at random 20-30% of the subject population to be reviewed. Otherwise, all records will be reviewed.
 - b. In the case of a for-cause audit, the IRB may request a 100% audit of study participants' records.
9. A pre-audit interview may be conducted with the investigator or other key research personnel to document the delegation of authority related to the following activities:
 - a. Regulatory affairs/IRB submissions;
 - b. Obtaining informed consent
 - c. Recruitment of study participants;
 - d. Reporting of adverse events/protocol deviations;
 - e. Reporting of injury or other unforeseen events to the IRB/sponsor;
 - f. Maintaining study documentation/clinical report forms;
 - g. Test article accountability;
 - h. Monitoring by the sponsor/clinical research organization; and
 - i. Verification of continuing review reports.
10. A report of audit findings will be prepared and submitted to the IRB for review and action, and a copy of the audit report will be sent to the principal investigator.
11. If the results of the audit identify outstanding issues, a letter outlining the basis for the findings and requesting needed explanations, corrective action plans and/or study revisions will be sent to the investigator.

12. If preliminary findings so indicate, the IRB may suspend the study enrollment or activities or terminate the study and take appropriate action to ensure the safety and welfare of the subjects.
13. The principal investigator may be required to appear before the full Board or to meet with an IRB-appointed investigative subcommittee to address issues identified by audit. However, the investigator may not have attorneys or other witnesses present at the meetings.
14. The IRB may engage any outside consultant or expert as necessary to conduct the audit.
15. If subjects are considered at risk due to the actions of the investigator or other key research personnel, appropriate officials of the institution in which the research is occurring and the sponsor of the research will be notified, and appropriate action will be taken to ensure the safety and welfare of the subjects.
16. Audit reports, corrective action plans, and correspondence with investigators will be transmitted to appropriate officials of the institution in which the research is occurring as necessary to assure proper protection for the rights and welfare of human subjects.
17. Copies of audit reports and correspondence will be placed in the IRB study files and kept by the compliance staff.
18. Follow-up audits will be scheduled when substantial deficiencies have been identified whose correction is crucial in providing adequate protection for the rights and welfare of subjects.

**UNIVERSITY OF TENNESSEE COLLEGE OF MEDICINE
CHATTANOOGA/
ERLANGER HEALTH SYSTEM
INSTITUTIONAL REVIEW BOARD
031: UTILIZATION OF THE NCI CIRB**

I. PURPOSE

To specify the procedures for utilizing the NCI CIRB for studies conducted by investigators at the University of Tennessee College of Medicine Chattanooga.

II. SCOPE

This SOP applies to the IRB administrator, IRB members, compliance auditing staff, and investigators

Personnel Responsible

IRB administrator, IRB members, and investigators

III. BACKGROUND

The NCI CIRB Initiative is a cooperative venture with local IRBs that is intended to create a more effective and efficient mechanism for IRB oversight of NCI-sponsored Cooperative Group clinical trials. Specifically, the NCI CIRB is designed to: 1) improve access to NCI-sponsored Cooperative Group clinical trials for potential study participants and their physicians by enabling local IRBs to rapidly approve clinical trials through the use of a facilitated review process; 2) enhance the protection of study participants by providing consistent expert IRB review at the national level; and 3) reduce the administrative burden for local IRBs and research staff. Under an authorization agreement with the NCI CIRB, the UTCOMC/EHS IRB is able to perform a facilitated administrative review of any NCI-sponsored Cooperative Group study that has been approved through the NCI CIRB and in which participation is requested by an investigator at UTCOMC or an affiliated institution. The UTCOMC/EHS IRB decides for each individual study whether to accept the CIRB review or to perform full IRB review of the study.

If the CIRB's review is accepted by the UTCOMC/EHS IRB, the CIRB becomes the IRB of record for the study and is responsible for review of amendments, continuing reviews, review of adverse events distributed by the Cooperative Group coordinating the study, and review of information distributed by the Cooperative Group coordinating the study intended for use by current or prospective

study participants. The UTCOMC/EHS IRB maintains responsibilities for local oversight of performance of the study. These responsibilities involve ensuring the safe and appropriate performance of the research at its affiliated institutions including, but not limited to, considering local context issues in the implementation of studies (such as applicable laws, institutional policies and demographic/cultural issues of the local population), monitoring protocol compliance, addressing any major protocol violations, managing any serious adverse events, determining qualifications of research staff, and providing a mechanism by which complaints about the research can be made by local study participants or others.

In accordance with:

National Cancer Institute Central Institutional Review Board
Handbook for Local Sites
http://www.ncicirb.org/CIRB_Handbook.pdf

Compliance with this policy also requires compliance with state or local laws or regulations that provide additional protections for human subjects.

IV. PROCEDURES

1. When an investigator wishes to open a Cooperative Group clinical trial that has been approved by the NCI CIRB, the following steps must be followed to conduct a facilitated review:
 - a. The investigator/research staff will complete the Form A application and submit one copy of each of the following documents obtained from the CIRB Website (www.ncicirb.org):
 - i. CIRB application;
 - ii. Study protocol;
 - iii. CIRB final approval letter;
 - iv. CIRB approved informed consent document; and
 - v. a modified informed consent document using the UTCOMC/EHS template with required local elements.
 - b. CIRB study submissions are subject to the same agenda deadlines as other IRB agenda submission items.
 - c. All new CIRB protocols listed for review will have a facilitated review performed by the IRB Chair or his/her designee for the review of CIRB protocols.
 - d. The individual conducting the facilitated review will consider local context issues when reviewing the study and informed consent document. Local context issues considered by the UTCOMC/EHS IRB include, but are not limited to: local and

- state laws; institutional policies; local investigator credentials; and demographics/cultural issues of the local population.
- e. The UTCOMC/EHS IRB may make minor word substitutions and/or additions to the informed consent document to facilitate comprehension by the local population, but may not make changes that alter the meaning of the text. Deletions are not allowed. If the UTCOMC/EHS IRB requires text changes that alter the meaning of the text, the protocol will require full board review at the local level, facilitated review may not be used, and the CIRB cannot serve as the IRB of record for the protocol at the local site.
 - f. The IRB Chair or Designee shall determine whether to accept the CIRB review of the study or to require submission of the study for full review by the UTCOMC/EHS IRB. Review comments, if any, and the decision to either accept or not accept the CIRB review shall be sent to the UTCOMC/EHS IRB administrator within 24 hours of the review.
 - g. The IRB administrator will notify the CIRB Administrative Office of facilitated review acceptance via the website within 24 hours of notification of the IRB Chair's or Designee's decision.
 - h. The IRB administrator will list the study on the upcoming IRB agenda in the "facilitated review" category. Studies designated for full local IRB review will be listed on a subsequent agenda for such review.
 - i. The expiration date of CIRB studies will be the UTCOMC/EHS expiration date.
 - j. Documentation of the facilitated review acceptance by the local IRB Chair or Designee of a new CIRB study will be noted in the UTCOMC/EHS IRB minutes.
 - k. A copy of the initial review documents will be maintained in the local IRB study file.
2. As a condition of accepting the CIRB review, the UTCOMC/EHS IRB will require the following routine modifications in the CIRB consent document:
- a. The consent form must be prepared with the UTCOMC/EHS template ;
 - b. Pages must be numbered ;
 - c. A line must be inserted for the research subject's initials or initials of the legally authorized representative (LAR) at the bottom of all pages except the signature page;
 - d. A brief title and the principal investigator's name must be inserted at the top of all pages (except the title page);
 - e. At either the top or bottom of each page of the consent form there must be added a "preparation date ____". (This date changes whenever a revision is made to the consent form.)

- f. The confidentiality section of the consent form must include the HIPAA authorization language utilized by the UTCOMC/EHS IRB main consent form template.
 - g. The compensation for injury section must include the standard compensation disclaimer contained in the UTCOMC/EHS IRB main consent form template.
 - h. The signature line section of the consent form must be formatted according to the UTCOMC/EHS IRB main consent form template.
3. For CIRB studies accepted by the UTCOMC/EHS IRB, the CIRB will become the IRB of record for the protocol, and the CIRB will be responsible for continuing review, review of subsequent amendments, and assessment of non-local, serious adverse events as notified by the cooperative group.
4. The CIRB conducts continuing review for all studies on its menu. Local IRBs do not have to conduct a continuing review for studies for which the CIRB is the IRB of record. However, the local principal investigator will submit to the UTCOMC/EHS IRB all documents related to the continuing review and renewal of studies for which the CIRB is the IRB of record.
5. The CIRB reviews amendments for all studies on its menu. Amendments of CIRB-approved studies will not be reviewed by the local IRB. However, the local principal investigator will submit to the UTCOMC/EHS IRB all documents related to the review and approval of revisions for all studies for which the CIRB is the IRB of record. When an amendment includes changes in the informed consent document, the investigator/research staff will submit one copy of the updated informed consent document to the UTCOMC/IRB for stamping of the approval date.
6. Serious adverse events or unanticipated problems that do not involve study participants of the local study site(s) should not be submitted to the UTCOMC/EHS IRB. Serious adverse events or unanticipated problems involving a study participant from UTCOMC/EHS clinical sites should be submitted in the usual manner per the UTCOMC/EHS IRB standard operating procedure (see IRB SOP #17, Reporting Unanticipated Problems, including Adverse Events).
7. Cooperative Group studies currently approved by the UTCOMC/EHS IRB may be transferred to the CIRB. Each study should be submitted to the UTCOMC/EHS IRB as an initial review (see Section 1 for the detailed process) and the facilitated review should be reported to the CIRB and included in the UTCOMC/EHS IRB minutes as outlined in Section 1. For studies transferred to the CIRB, a note-to-regulatory-file should state that the protocol was transferred to the CIRB with

an effective date that matches the date on which the NCI CIRB Facilitated Review Acceptance Form was submitted to the CIRB. Enrolled study participants do not have to be re-consented as the institution's informed consent document will continue to be used and the study remains under local IRB performance oversight.

8. The UTCOMC/EHS IRB maintains responsibilities for local oversight of performance of studies transferred to the CIRB. These responsibilities involve ensuring the safe and appropriate performance of the research at its affiliated institutions including, but not limited to, considering local context issues in the implementation of studies (such as applicable laws, institutional policies and demographic/cultural issues of the local population), monitoring protocol compliance, addressing any major protocol violations, managing any reportable local adverse events, determining qualifications of research staff, and providing a mechanism by which complaints about the research can be made by local study participants or others.

Appendix A: Event reporting with Form I (Waiver, Deviation, Violation)

