Centralized Institutional Review Boards: Assessing the Arguments and Evidence

By David B. Resnik

Abstract

This article considers the arguments for and against centralized review of multisite research with human participants. Minimizing delays, saving costs, reducing investigator burden, and promoting consistency lend support to centralized review. Providing cultural context, addressing community needs and concerns, communicating effectively with investigators, and managing legal risks weigh against centralization. Some common approaches to centralized review include various types of reliance agreements, institutional review board (IRB) collaboration, IRB reciprocity, independent IRBs, central IRBs, and national or regional IRBs. Since each approach has advantages and disadvantages, research institutions and funding organizations should continue to experiment with different types of centralized review to determine which approach works best under specific conditions. While encouraging institutions and organizations to develop and implement different models of centralized review is a good idea, legally mandating a particular form may be unwise at this time. Further study and experience is needed on the benefits and risks of different types of centralized review.

Introduction

Federal regulations mandated institutional review boards (IRBs) over 30 years ago to serve as local committees to review and oversee the ethical aspects of research involving human subjects. The Department of Health and Human Services (DHHS) research regulations, known as the Common Rule, and the Food and Drug Administration (FDA) regulations both require that institutions establish IRBs to take responsibility for reviewing and overseeing research with human participants (DHHS 2009, FDA 2010). The regulations also permit institutions to delegate the responsibility for IRB review to another institution when they are engaged in cooperative research projects, such as multicenter clinical trials, to avoid duplicative review (DHHS 2009, FDA 2010). When the DHHS and FDA regulations were first adopted, collaborative projects involving numerous institutions were not as common as they are today. However, the research environment has changed considerably since the 1970s, and biomedical research has become more complex, expensive and collaborative. The volume of research has also increased dramatically (DHHS 1998, Burman et al. 2001, Emanuel et al. 2004). Some have argued that the federal research regulations need to be updated to reflect these changes (Moreno et al. 1998, Emanuel et al. 2004, Emanuel and Menikoff 2011).

On July 26, 2011, the Office of Human Research Protections (OHRP) and the FDA announced an Advance Notice of Proposed Rulemaking (ANPRM) asking for public comment on proposals for amending the DHHS and FDA regulations. One proposal floated by the agencies was to change the regulations to require a single IRB of record for all multisite research, except FDA-regulated device studies (OHRP and FDA, 2011). Changes to the federal regulations have not yet been approved as of the writing of this article.

The idea of using alternatives to local IRB review of cooperative research is not new. In 2001, the National Bioethics Advisory Commission (NBAC) recommended that institutions consider alternative models of IRB review for multisite research to streamline oversight and
reduce redundant review (NBAC 2001). During its October 2004 meetings, the Secretary’s Advisory Committee on Human Research Protections (SACHRP) heard several presentations on alternative models of IRB review and the advantages and disadvantages of local review. SACHRP recommended that OHRP, FDA and other agencies hold workshops on alternative models of IRB review (SACHRP 2004). In 2005 and 2006, OHRP and several other organizations sponsored workshops examining alternative models of IRB review for multisite research (OHRP 2005, 2006). One workshop identified 10 different models of IRB review for multisite research (OHRP 2005).

OHRP has encouraged the development of alternative models of IRB review for multisite research by proposing that only the IRB of record be accountable for regulatory oversight when one institution relies on another for IRB review. OHRP has also developed a template for reliance agreements to facilitate negotiations between institutions (Menikoff 2010). The FDA (2012) has stated that only the IRB of record is responsible for regulatory compliance when one institution relies on another for IRB review, although the local investigators and institution are still responsible for the conduct of the study. Despite the efforts of OHRP and the FDA, research institutions have been slow to adopt alternative models of IRB review, and local IRB review of multisite research remains the norm (Silberman and Kahn 2011).

This article will assess the arguments and evidence for and against centralized IRB review of multisite research and consider some models of centralized review. It will argue that encouraging institutions and organizations to develop and implement some model of centralized IRB is a good idea, but mandating a particular form of centralized review is unwise at this time.

**What is Centralized IRB Review?**

There are different types of centralized review. The following are some common approaches:

**Reliance Agreement for a Single Study**

This is the most common form of centralized review. In this type of arrangement, cooperating institutions enter a reliance agreement in which a single institution assumes responsibility for IRB review for a particular study. That institution becomes the IRB of record. The agreement also spells out the obligations of each party. Usually, the relied-upon institution agrees to provide the relying institution with updates about the research, such as continuing reviews, and other important information (OHRP 2005).

**Reliance Agreement for Multiple Studies**

In this type of arrangement, institutions enter into a reliance agreement for multiple studies named in the agreement. The relied-upon institution becomes the IRB of record for these studies and provides the relying institution with updates about the research.

**Reliance Agreement for an Indefinite Number of Studies**

Under this arrangement, institutions enter into an agreement for IRB review, without naming particular studies in the agreement. For example, a community hospital might reach an agreement with an academic medical center for IRB review or a contract research organization might rely on an independent, for-profit IRB. The Biomedical Research Alliance of New York (BRANY), which includes over 100 institutions in the New York area, is an example of this type of arrangement. BRANY provides research support for its members and a central IRB that they can use. The BRANY IRB becomes the IRB of record when member institutions rely on it for review (Koski et al. 2005). In the Harvard Catalyst network, 11
institutions in the Boston, MA area have agreed to “ceded review” of multisite research. Under this arrangement, if the research is conducted at the participating institutions, an investigator can request that only one of the IRBs serve as the IRB of record. The IRBs then decide whether to cede review to a single IRB or maintain local review (Harvard Catalyst 2012).

**IRB Collaborations**

IRBs from different institutions collaborate on multisite research. They share materials and resources to streamline review and reduce the workload, but they do not enter into formal reliance agreements. IRBNet, established by Dartmouth College and Children’s Hospital of Philadelphia, is an example of this type of arrangement (Koski et al. 2005).

**IRB Reciprocity**

Some institutions have developed arrangements in which they agree to accept each other’s IRB reviews, while still addressing local concerns. The IRB at one institution serves as the primary reviewing body. While this process facilitates and expedites IRB review among cooperating institutions, it does not eliminate local IRB review, and there is no single IRB of record for this research (Koski et al. 2005). The Multicenter Academic Clinical Research Organization (MACRO), which includes Baylor College of Medicine, University of Alabama at Birmingham, University of Pennsylvania School of Medicine, Vanderbilt University, and Washington University School of Medicine, is an example of this type of arrangement (Koski et al. 2005).

**Independent IRB**

Under this arrangement, institutions participating in a multisite study, such as a clinical trial, agree to have an independent IRB review the research. The independent IRB becomes the IRB of record. The independent IRB provides the institutions with updates about the research (OHRP 2005). Some examples of independent IRBs include Chesapeake Research Review, New England IRB, Quorum Review IRB, and Western IRB.

**Central IRB**

This arrangement has been developed by the National Cancer Institute (NCI), which began using a central IRB (CIRB) for reviewing cooperative oncology research in 2001. Under this model, a cooperative oncology group sponsored by the NCI prepares materials for IRB review, such as the protocol, data collection forms, standard operating procedures, consent documents, and advertisements. IRBs at participating sites conduct a facilitated review of the materials, concentrating on local issues. The local IRBs may make modifications to the research, which are then approved by the NCI’s CIRB. The local IRBs rely on the CIRB for continuing review of the research, amendments and oversight of data and safety monitoring. Although they are no longer the IRB of record, local IRBs are still responsible for handling local problems, such as adverse events and protocol violations (Wagner et al. 2010, NCI 2012).

**National or Regional IRB**

A broader type of central IRB is a national or regional IRB, in which a single IRB reviews all research within a particular geographic area. Institutions within that area submit their studies to the IRB under a reliance agreement. The national or regional IRB serves as the IRB of record. The Indian Health Service (IHS) is an example of this type of arrangement. One of several IHS IRBs reviews research conducted at different tribes. Some tribes have their own IRBs as well (OHRP 2005).
The Belmont Principles

In thinking about the arguments pertaining to centralized review, it is useful to refer to the *Belmont Report*’s principles: respect for persons, beneficence and justice (National Commission 1979). These widely recognized ethical standards provide the conceptual foundation for the federal regulations and have had considerable influence over policies and guidelines related to research with human participants (Childress et al. 2005). Respect for persons requires that individuals be treated as autonomous agents and that individuals with diminished autonomy should have extra protection. The practical import of this principle is that competent individuals should make an informed choice to participate in research and vulnerable individuals, such as children or incompetent adults, should be protected from harm or exploitation. Beneficence requires that investigators maximize the benefits and minimize the risks of research to participants and society. Many of the procedures used to protect participants from harm, such as inclusion/exclusion criteria, data and safety monitoring, and adverse event reporting, help to promote beneficence. Justice requires that the benefits and risks of research be distributed fairly. One of the practical consequences of this principle is that the selection of participants should be equitable. According to the authors of the *Belmont Report*, one should balance these different principles when making decisions concerning research ethics and policy (National Commission 1979). Considering the arguments in light of these principles will help us better understand whether local review or centralized review is better at promoting ethical oversight of research with human participants.

Arguments for Centralized Review

There are several strong arguments for centralized IRB review of multisite research. All of these address, in some way, the inefficiencies of local review (Koski et al. 2005, Silberman and Kahn 2011). Though inefficiency is not by itself an ethical concern, it can become one if resources could be better used elsewhere (Burman et al. 2001, Koski et al, 2005). The time and effort that a local IRB spends on reviewing a cooperative research study could be better used for more thorough review of other, non-multisite studies, or for oversight activities, audits, education, quality assurance/improvement, and adverse event management. The investigator’s resources could also be better spent. If an investigator spends fewer resources on IRB submissions, he (or she) can devote more resources to other activities directly related to protecting human participants, such as informed consent, recruitment, risk minimization, and communicating with staff. Thus, efficient IRB review can indirectly promote beneficence (by minimizing harms) and respect for persons (by promoting ethical consent and recruitment).

The IRB literature has documented various inefficiencies related to local review of multisite research. First, centralized review of multisite research can reduce delays. Local review can significantly delay research projects as protocols and other documents must be reviewed and approved by numerous IRBs before multisite studies can be initiated. Sometimes the IRBs may disagree about changes to the research, which may require some back and forth before the project can be approved. Delays due to local review of multisite research can range from several weeks to several months (Silberman and Kahn 2011). One study found that the time to complete initial IRB review of multisite research ranged from 52 to 798 days, with a median of 286 days (Green et al. 2006). A study of the NCI’s CIRB found that the time from IRB submission to approval was 22.4 days less, on average, for studies that used the CIRB as compared to those that did not (Wagner et al. 2010).

Second, centralized review can reduce costs. There is considerable evidence that local IRB review of multisite research can increase costs. Costs include expenses related to the investigator’s work, such as preparing IRB submissions, responding to IRB stipulations and
queries, and submitting amendments, adverse events reports, and protocol violations, as well as expenses related to IRB review, such as support staff and administration (Silberman and Kahn 2011). One study found that the costs for local IRB review (excluding investigator’s costs) averaged $1,060 for full board review, $1,067 for expedited review, and $271 for continuing review. The costs were significantly lower for high-volume IRBs (700 or more studies): $839 for full board review, $602 for expedited review, and $240 for continuing review (Sugarman et al. 2005). Other studies have found considerable variability in IRB costs, with the average costs being much higher for low-volume institutions (Byrne et al. 2006, Silbermann and Kahn 2011). One study examining total IRB review costs found that, for a randomized, controlled trial submitted to 45 institutions, the total costs were $107,544, including $82,610 in IRB fees and $24,934 in labor by the investigator and research staff (Ravina et al. 2006). A study of the NCI’s CIRB found that institutions that used the CIRB saved an average of $717 per initial IRB review when compared to institutions that did not use the CIRB (Wagner et al. 2010).

Third, centralized review can reduce the burden on investigators and research staff and free up their time for other activities related to protection of human participants, such as informed consent and recruitment. (Koski et al. 2005). Reducing investigator burden involves more than just saving time and money, since the IRB review process can mentally and emotionally tax investigators and research staff. Centralizing IRB review can help reduce psychological stress, confusion and frustration.

On the other hand, proponents of local review in multisite research could admit that it increases costs, delays and burdens on investigators, but still argue that it is a worthwhile use of resources. Concerns about efficiency should not take precedence over the protection of human participants. If local review helps to safeguard the rights and welfare of participants and promotes justice, then it should not be abandoned to save time, money or aggravation.

Fourth, centralized IRB review can promote consistency in human participant protection. Numerous studies have documented the variability in local IRB review of multisite research (Silberman and Kahn 2011). One study of 42 IRBs found a full range of responses to a protocol designed to be approvable as minimal risk under the U.S. regulations. One IRB found that it was exempt from review, 10 gave it expedited review, 31 gave it full board review, and one rejected it as too risky. Twelve IRBs requested revisions that increased the risks to the participants and 23 required inappropriate changes to the consent document (Green et al. 2006). Another study submitted the same genetic epidemiology research project to 31 IRBs. Seven gave it expedited review, while 24 gave it full board review. Fifteen IRBs required two or more consent documents and 10 did not require a child’s assent (McWilliams et al. 2003). In another study, researchers submitted a randomized, controlled trial comparing two hospital pre-resuscitation strategies to 24 IRBs. Four IRBs accepted the submission with no changes and ten required multiple revisions (Mosesso et al. 2004). In an observational study of children presenting to emergency departments submitted to 34 IRBs, 13 approved it with no changes, 18 approved it with revisions, and three deferred the approval (Mansbach et al. 2007).

Variation in IRB decisions raises three types of ethical concerns. First, contradictory IRB requirements can lead to cost increases, frustration and delays, as investigators negotiate with different IRBs while shepherding their projects through the approval process. Second, variation in IRB practices suggests that IRBs are interpreting research regulations differently, and they cannot all be correct. Although it is often the case that more than one interpretation is acceptable in a particular situation, it is also possible that IRBs sometimes disagree because one IRB lacks a sound understanding of the research or the regulations. When this occurs, human participants may not be protected adequately because an IRB is not doing its job. Although a central IRB may still interpret regulations incorrectly, it will be
less likely to err than a local IRB because it will presumably have more experience. Third, if IRBs reach different decisions concerning the same research proposal, then human participants may not receive equal protection. Participants in the same clinical trial may be treated differently at one institution than at another. Equal protection is important in promoting justice in research because justice requires that similar cases are treated similarly (Rawls 1971).

Proponents of local IRBs may admit that inconsistency in IRB decisions does occur but maintain that some variation is to be expected if local IRBs take local context into account. An IRB located in an Appalachian community might make some changes to a consent form that an IRB located in a metropolitan area would not make, based on its knowledge of the population. An IRB located on a Native American reservation might require full board review to address issues unique to the community, such as stigma and provision of health care, whereas an IRB located in a metropolitan area might not require full board review. As long as inconsistent IRB decisions do not undermine the protection of human participants, some local variation is acceptable.

Arguments against Centralized Review

There are several arguments against centralized IRB review in multisite research. The first argument appeals to the respect-for-persons and beneficence principles. Many have argued that local IRBs can provide better review of consent forms, advertisements, recruitment strategies, and survey documents than centralized IRBs because they have a better understanding of the local cultural context, which may include social, ethnic, linguistic, economic and other factors pertinent to the local population (Levine 2004, Koski et al. 2005). A local IRB may have a better understanding of how to word a consent document or a questionnaire for a specific population, such as a Native American community in Arizona or migrant workers in North Carolina. A local IRB may have a better understanding of the most appropriate languages and dialects to use when translating consent documents, surveys and other materials. A local IRB may do a better job of ensuring that advertisements, recruitment letters, and incentives for participation are culturally appropriate (Levine 2004, Koski et al. 2005, Wechsler 2007, Klitzman 2011).

Although it seems intuitively plausible that review by a local IRB can best promote protection of local human participants, the evidence supporting this idea is inconclusive. Only a few studies have examined the impact of local review on consent and recruitment. Some studies have found that local IRBs in multisite studies often require changes to consent forms that have little bearing on the protection of research participants (Silberman and Kahn 2011). One study found that changes required by local IRBs in a multisite clinical trial had little to do with local context. None of the IRBs required substantial changes to the protocol. Most of the changes involved adding institutional language to the consent document, such as compensation for injury policies or HIPAA privacy protections. In other words, the local IRBs appeared to be protecting the local institutions, not the local subjects. The IRBs also required changes concerning the qualifications of local investigators and potential conflicts of interest. The required changes increased the average length of the consent document and reading level (Ravina et al. 2010). Another study found that most changes (85.2%) required by local IRBs in two multisite tuberculosis treatment trials involved minor wording revisions that did not affect the content of the documents but increased the length and the reading level. In addition, 11.2% of the changes introduced language into the consent document that misrepresented the research (Burman et al. 2003).

One study found some support for the notion that local IRBs enhance the consent process. This study examined the discussion of alternatives to research participation in oncology
consent forms. The study found that forms approved by a local IRB rated significantly higher than model forms approved by a cooperative oncology group (Resnik et al. 2010). Clearly, more research is needed to determine whether local IRB review has a positive impact on protection of human participants and whether those benefits can be achieved with central review.

Proponents of centralized review may argue that, even if there is some evidence that local IRBs enhance consent and recruitment, these functions can be handled by central boards if greater attention is paid to the local cultural context (Foster 2004, Gold and Dewa 2005, OHRP 2005, Koski et al. 2005). For example, a central IRB could solicit input from a local committee on the consent document and other materials, or a central board could include members who represent local populations. The NCI’s central IRB, discussed above, solicits local input on consent and recruitment issues. The central board develops a general consent form that can be modified by local committees. The local committees concentrate on issues relevant to their populations (OHRP 2005, Wagner et al. 2010).

A second argument against centralized review appeals to the justice principle. There are two kinds of justice relevant to research with human participants: distributive justice and procedural justice. Distributive justice addresses the fair distribution of the benefits and burdens of research; procedural justice relates to the fairness of decision-making related to the review and oversight of research (Rawls 1971, Kahn et al. 1998). An IRB can promote distributive justice by ensuring that benefits accrue to the local community and risks are minimized, and the subject selection is equitable. An IRB can promote procedural justice by involving the local community in decisions pertaining to the review of research.

A local IRB that Performs competent review may do a better job at promoting justice in research than a centralized board because a local IRB has a better understanding of the needs and concerns of the local population, and it has a better relationship with the community. A local IRB is more likely than a central IRB to be sensitive to the population’s concerns about discrimination, stigma, provision of health care, privacy protections, return of research results, and the use of data and biological samples (Levine 2004, Moon and Khin-Maung-Gyi 2009). Local IRBs may be more accountable and accessible than central IRBs, because local IRB members live in the community and interact with community members on a daily basis. Local IRB review may be especially important in community-based participatory research (CBPR) because this research approach aims to involve community members in all phases of research, including protocol development, review of consent forms, subject recruitment, and dissemination of findings. CBPR is a useful strategy for conducting population-based studies in epidemiology, public health, and social science (O’Fallon and Dearry 2002).

There has been little, if any, empirical research on issues related to justice as it pertains to centralized IRB review. Proponents of central IRBs could argue that concerns about justice can be handled without local IRB review, provided the local institution engages with members of the population and relays the community’s needs and concerns to the central IRB. If the NCI’s model is followed, community issues could be addressed during the facilitated review of research by the local institution (OHRP 2005). However, it is not known whether centralized review can adequately substitute for local review with respect to addressing local needs and concerns, and more empirical research is needed on this topic. Also, centralized review appears to be incompatible with CBPR because this research approach involves the community in a fundamental way in research planning, implementation and review.

The third argument against centralized review is that local boards communicate more effectively with investigators than centralized IRBs. IRB chairs and administrative staff can meet with investigators in person, which may be preferable to trying to reach someone by
phone or email. They may be available for appointments or informal, "curbside" discussions. IRB chairs and administrative staff are also likely to know the investigators personally and have a productive relationship with them. Investigators may feel more comfortable working with a local IRB than with a central board or board chair who can be hard to reach, especially when they have problems that require urgent attention, such as serious adverse events or protocol violations (Klitzman 2011). Although relationships between investigators and local IRBs can produce antagonism, they are generally more conducive to good communication than long-distance ones. Communicating effectively with investigators helps satisfy the beneficence principle. Effective communication between investigators and the IRB is important for protecting participants from harm and complying with regulations and institutional policies.

A proponent of centralization could argue that the way to deal with these communication issues is to ensure that the local institution takes responsibility for working with investigators and dealing with on-site problems (Koski et al. 2005). The local committee can coordinate with the central board to protect human participants and promote research compliance. For example, if an investigator needs immediate help, he or she can contact someone on site, who can inform the central IRB about the issue. The central IRB may advise the on-site person on how to handle the situation. Because it is not known how effective central IRBs are at working with investigators, more research is needed on this topic.

The fourth argument against centralization is to minimize legal liability (Wechsler 2007). While OHRP and FDA have reduced some liability by stating their intent to only hold the IRB of record accountable for multisite research, there are other legal issues besides OHRP/FDA sanctions. Institutions that sign reliance agreements for the review of research involving human participants still have legal responsibilities to individuals who participate in their studies. If a human participant is injured at one of the local sites in a multisite study and the site is relying on another institution for IRB review, the local site can still be sued for negligence, fraud or some other tort, although it may reduce some of its liability by shifting responsibility to the other institution or seeking indemnification (Resnik 2004). Institutions still face liability for violations of the health information privacy rules in the Health Information Portability and Accountability Act (HIPAA). Many institutions believe that the best way to deal with these liability issues is to retain local control over IRB review (Foster 2004, Koski et al. 2005). While liability concerns may have little to do with ethics, they do have considerable influence on institutional decisions.

At first glance, liability concerns do not appear to address any of the Belmont principles. However, one might argue that dealing with liability issues indirectly promotes beneficence, because preventing harm to participants is vital to managing legal risks. Thus, reducing legal risks can indirectly protect human participants. Moreover, managing legal risks properly can avoid costly and time-consuming lawsuits. Resources that are not used in litigation can be spent on other areas that protect human participants, such as education and quality assurance and improvement. Thus, legal risk management can promote efficient use of resources, as discussed above.

Proponents of centralization could argue that liability risks can be minimized as long as institutions maintain local oversight of research, which they can still do even when IRB review is centralized (Koski et al. 2005). An institution that relies on a central IRB for review could minimize its liability by ensuring that the local IRB handles adverse events, audits and other compliance issues. Educational and policy initiatives at the local institution could also help to minimize liability. Since there has been little legal scholarship on liability issues related to central IRBs, more research is needed on this topic.
Assessing the Arguments and Evidence

As summarized in Table 1 below, there are a variety of arguments for both local and centralized IRB review of multisite research. Each side of this debate can offer cogent arguments to support its position. Minimizing delays, saving costs, reducing investigator burden, and promoting consistency lend support to centralized review. Providing cultural context, addressing community needs and concerns, communicating effectively with investigators, and managing legal risks weigh against centralized review. These arguments reflect the general tension between increasing the efficiency of review and protecting human participants and communities. Proponents of centralization argue that it is possible to increase the efficiency of review without compromising protection of human participants and communities, and that increases in efficiency can actually promote ethical research by freeing up resources for activities that enhance safety, consent, staff training, public communication, and protocol implementation. Opponents acknowledge that some increases in efficiency can help promote the protection of participants and communities, but they argue that others do not. Centralization should be avoided when it compromises protection of participants or communities.

Table 1: Arguments for Local versus Centralized IRB Review

<table>
<thead>
<tr>
<th>For Local Review</th>
<th>For Centralized Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides cultural context</td>
<td>Minimizes delays</td>
</tr>
<tr>
<td>Addresses community needs and concerns</td>
<td>Saves money and other resources</td>
</tr>
<tr>
<td>Promotes effective communication with investigators</td>
<td>Reduces investigator burden</td>
</tr>
<tr>
<td>Manages legal risks</td>
<td>Promotes consistency in review</td>
</tr>
</tbody>
</table>

Determining the best form of review in any particular case depends on a careful assessment of relevant factors (e.g. efficiency, cultural context) in light of ethical considerations, such as respect for persons, beneficence and justice. Because the arguments for and against centralized review are complex and depend on specific facts and circumstances, it may not be wise to adopt a single policy that applies to all types of multisite research. Different types of centralized review may be appropriate in different circumstances. For example, centralized review may be the best approach for multicenter studies of clinical trials of new drugs, biologics and medical devices. However, it may not be the best option for epidemiological, public health, or social science multisite research, in which cultural context and community needs and concerns are paramount. Centralized review also may not be appropriate for innovative, high-risk research, such as stem cell or gene therapy, due to safety and liability concerns. IRB cooperation or reciprocity (or perhaps no centralization) may be the best approach in these situations. Centralized IRB review also may not be appropriate when some of the research sites are located in foreign countries, due to significant differences in laws and cultural context. If a cooperative study involves only a few institutions, the easiest way to centralize review may be to use reliance agreements, rather than setting up a CIRB or relying on an independent IRB. Reliance agreements may also be appropriate if two or more institutions have an ongoing, collaborative relationship for the conduct of research.

The ANPRM announced by OHRP and FDA floated the idea of requiring a single IRB of record for all multisite research. One might argue, however, that this proposed requirement is not flexible enough, and that institutions should be free to experiment with different approaches to centralized review, because what works in one situation may not work in another. In
some types of clinical trials, cultural context and community needs and concerns may trump considerations related to efficiency. For example, a single IRB of record may not be an appropriate option for a multisite, clinical trial of a technique for reducing infections in rural hospitals because of the importance of addressing local needs and concerns (such as health care access) when implementing this study. A single IRB of record also may not be a good choice for a multisite, clinical trial of a treatment for post-traumatic stress disorder taking place in some regions because of the importance of cultural context in consent, recruitment and the wording of survey questions.

Conclusion
Centralized IRB review is a worthwhile idea that can play an important role in promoting efficient and effective review and oversight of multisite research with human participants. Some common approaches to centralized review include reliance agreements for IRB review, IRB collaboration, IRB reciprocity, independent IRBs, central IRBs, and national or regional IRBs. Since each approach has advantages and disadvantages, research institutions and study sponsors should continue to experiment with different types of centralized review to determine which approaches work best under specific conditions. While encouraging institutions and organizations to develop and implement different models of centralized IRB is a good idea, mandating a particular form of centralized review may be unwise at this time. Further study and experience are needed on the benefits, risks and implementation of different types of centralized review.

Acknowledgments
This article is the work product of an employee or group of employees of the National Institute of Environmental Health Sciences (NIEHS), National Institutes of Health (NIH), however, the statements, opinions or conclusions contained therein do not necessarily represent the statements, opinions or conclusions of the NIEHS, the NIH, or the United States government.

References


Author

David B. Resnik, JD, PhD is a Bioethicist and IRB Chair at the National Institute of Environmental Health Science, National Institutes of Health. Contact him at 1.919.541.5658 or resnikd@niehs.nih.gov.