Boston Medical Center and Boston University Medical Campus Human Research Protection Program Policies and Procedures

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1. Introduction

1.1 The Human Research Protection Program (HRPP)

1.1.1 HRPP Components

(Revised 10/23/22)
Boston Medical Center and Boston University Medical Campus establish these policies and procedures to govern the conduct of research involving human subjects and all other activities which even in part involve such research, regardless of sponsorship. Boston Medical Center is the primary teaching hospital affiliate of the Boston University Chobanian & Avedisian School of Medicine. The Office of Human Research Affairs is responsible for the oversight of this human subjects research protection program.

Components of the HRPP are:

- The Boston Medical Center and Boston University Medical Campus Institutional Review Board (IRB); and
- The investigator and research staff education, training, and assistance programs described in Sections 6.2.3 and 6.4; and
- The research oversight activities, including targeted audits and Quality Assurance (QA) Reviews, described in Section 11.

Associated components contributing to the protection of human subjects are:

- Boston Medical Center and Boston University Medical Campus Clinical Research Resources Office (CRRO); and
- Investigational Pharmacy Services at Boston Medical Center; and
- Boston Medical Center Office of Grants Administration; and
- Boston University Office of Sponsored Programs; and
- Boston Medical Center Clinical Trial Office; and
- Boston Medical Center/Boston University Faculty Review Committee on Research Financial Conflicts of Interest; and
- Boston University Clinical and Translational Science Institute; and
- Boston University Office of Technology Development; and
- Boston Medical Center Compliance Department; and
- Boston University Office of Research Compliance; and
- Institutional Biosafety Committee; and
- Boston University Office of the General Counsel; and
- Boston Medical Center Office of the General Counsel.

1.1.2 IRB Institutions

(Revised 2/24/26)
The Boston Medical Center and Boston University Medical Campus Institutional Review Board (“the IRB”) is a joint activity of Boston Medical Center Corporation, Boston Medical Center Brighton, Boston Medical Center South, and Boston University Medical Campus under the federal Office for Human Research Protections as institutional organization number IORG0000222. The IRB was created in 1996 through the merger of the Boston City Hospital Human Studies Committee and Boston University Medical Center Institutional Review Board subsequent to the merger of Boston City Hospital and University Hospital. The IRB is listed as the IRB of record under the Federalwide Assurance (FWA) for Boston Medical Center Corporation, with component Boston Medical Center – Roslindale Medical and Dental Center (FWA00023612); and under the FWA for Boston University Medical Campus, with components Boston University Chobanian & Avedisian School of Medicine, Boston University School of Public Health, and Boston University Henry M. Goldman School of Dental Medicine (FWA00000301); and, effective March 1, 2026, under the FWA for Boston Medical Center Brighton (FWA00002570) and Boston Medical Center South (FWA00008719). Throughout this document, references to “Boston Medical Center” include Boston Medical Center Corporation, Boston Medical Center Brighton, and Boston Medical Center South.

These policies also apply to research at entities that have designated the IRB as their IRB of record under an FWA granted by the Office of Human Research Protections (OHRP).

1.2 Written Plan for the HRPP

(Revised 10/22/18)
The written plan for the Boston Medical Center and Boston University Medical Campus HRPP consists of this document, including supporting materials referenced herein. Exceptions to these policies and procedures are allowed if a written rationale and approval are provided by the IRB Director for IRB actions or by the HRPP Director for research oversight actions.

The process for maintaining the written plan includes a comprehensive review on an annual basis to be completed by September 1st of each year, as well as revisions on an as-needed basis in response to changes in referenced policies, laws, regulations, and recommendations; new scientific or ethical issues; quality assurance activities; or modified HRPP processes. This document starts with a Revision History denoting the sections that were changed at each revision.

The HRPP Director has the responsibility for guiding the review and revision process. The process starts with gathering proposed additions or revisions, either at the time of annual review or as needed. The HRPP Director may delegate the comprehensive review to the IRB Director, another appropriate IRB Office staff member, or ad hoc group. Next, proposed changes are presented to the HRPP Advisory Committee. Where possible, the HRPP Advisory Committee will come to a consensus on revisions; otherwise, their recommendations will occur by a majority vote of those present. The recommended revisions, along with any dissenting opinions from the HRPP Advisory Committee, are presented to the Institutional Officials (IOs), who have the ultimate responsibility for approving the revised document. For minor changes with no policy implications, the IRB Director or HRPP Director may present proposed revisions directly to the IOs for their approval.

The current approved version of this document is maintained on the OHRA website so as to be available to sponsors, researchers, research staff, other members of the research community, IRB members, points of contact at external institutions with which Boston Medical Center or Boston University Medical Campus have reliance agreements, and research participants. Communication of new policies occur through articles in the CR Times monthly newsletter, links on the OHRA website, instructions and help in the electronic system, training materials, and, if warranted, emails to users of the electronic system and to points of contact at external institutions, and presentations at seminars and department meetings.

1.3 Responsibilities of the HRPP

1.3.1 Role of the HRPP

(Revised 2/24/17)
The role of the HRPP and its associated components in the institutions is to protect the rights and welfare of human subjects of research and to assure that human research is conducted according to applicable federal, state, and local laws and regulations and the relevant policies of the HRPP, Boston Medical Center, and Boston University.

The HRPP fulfills this role by educating investigators, research staff, IRB members, and the community; by providing ethical review of human subjects research; by making research assistance available to investigators and research staff; by monitoring research activities and improving compliance; by providing a resource for research subjects; and by continuously assessing and improving the quality, efficiency, and effectiveness of the HRPP.

1.3.2 Measuring and Improving the HRPP

1.3.2.1 Principal Investigator Survey

(Revised 10/23/22)
When a new submission receives a determination (either approval or disapproval), the Principal Investigator is asked to complete a 6-question online user satisfaction survey. This brief survey asks the Principal Investigator to indicate strong agreement, agreement, disagreement, or strong disagreement with the following six statements:

Q1 The primary role of the IRB is to protect the rights and welfare of human subjects. In reviewing this research, the IRB was appropriately focused on this role.
Q2 In reviewing this research, the IRB dealt with me professionally and respectfully.
Q3 Given the details of this research, the IRB review time was acceptable.
Q4 For this research, the IRB focused on helping me overcome regulatory challenges and guiding me on appropriate paths forward, rather than just pointing out why the study did not meet the regulations.
Q5 The IRB often requests modifications or clarifications from investigators before they can approve a research study. For this protocol, those requests were clear, and I understood what the IRB was asking me to do, and why they were asking me to do it.
Q6 For this research, I found the software platform understandable and easy to use.

The trends in responses to this survey are monitored by the IRB Director and the HRPP Director and are used to identify areas for improvement and to assess the implementation of changes. Results from the survey are publicized on the IRB website and updated twice a year.

1.3.2.2 IRB Performance Metrics

(Revised 2/24/17)
Review times for submissions are monitored by the IRB Director on at least a monthly basis. The goal is to minimize the time spent on review of submissions by the IRB, consistent with providing a thorough and ethical review. Initiatives to improve IRB operations are assessed, in part, by their effect on review times.

Review times are publicized on the IRB website and updated four times a year.

1.3.2.3 Researcher Concerns and Suggestions

(Revised 10/22/18)
Researchers and research staff, including investigators at external sites relying on the IRB, are informed in several ways that they may bring forward concerns and suggestions about the HRPP, including the ethics review process at Boston Medical Center and Boston University Medical Campus or at an external IRB that is acting as the IRB of record. Each letter generated by the electronic system includes contact information for the letter signatory, who is a member of the IRB staff, the IRB Director, or an IRB Chair. The IRB website contains contact information for IRB staff and Chairs. The IRB Director regularly is invited to attend department meetings to meet with faculty members. The staff of the CRRO may receive concerns or suggestions from researchers and research staff during educational sessions or audits, and will direct them to the appropriate official, at least one supervisory level up from any person named as a source of the concern. Finally, both Boston Medical Center and Boston University maintain several avenues for employees to express concerns (such as Employee Assistance Programs, compliance hotlines, office of the ombuds), which will follow their internal reporting and confidentiality policies upon receiving any concerns relating to problems associated with the HRPP.

1.3.2.4 Quality Improvement Process

(Revised 8/11/19)
The HRPP Director is responsible for the continuous quality improvement of the HRPP. By September 1st of each year, the HRPP Director will develop a quality improvement plan for the coming year. The plan will be developed in consultation with other HRPP members and approved by the IOs. At least one goal concerning compliance and at least one goal concerning HRPP operations will be included in the plan,

together with a process to implement changes and to evaluate and communicate the success of those changes. Information from Principal Investigator surveys (see Section 1.3.2.1), IRB metrics (see Section 1.3.2.2), analysis of targeted audits and QA Reviews (see Section 11.3.3), IRB member, Chair, Vice Chair, IRB Director, and IRB staff evaluations (see Sections 3.3.5, 3.4.1.4, 3.4.2.4, 3.4.4.4, and 3.4.5.2), and researcher concerns and suggestions (see Section 1.3.2.3) will be used to identify goals, changes to mitigate problems, and success. The HRPP Director will periodically, as appropriate, post information on the IRB website and report to the IOs, HRPP Advisory Committee, IRB Members, and HRPP staff about the progress of the quality improvement initiatives and results.

1.4 Ethical Principles

(Revised 2/24/17)
The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research, written by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and published in 1979, delineates the ethical principles for the conduct of human research upon which the United States federal regulations are based.

The HRPP bases its deliberations and decision-making on the Belmont Principles in its goal to protect the rights and welfare of human subjects of research, while applying applicable federal, state, and local laws and regulations and the relevant policies of the Boston Medical Center and Boston University Medical Campus HRPP.

Those principles are:

Respect for persons involves recognition of the personal dignity and autonomy of individuals, and special protection of those persons with diminished autonomy.

Beneficence entails an obligation to protect persons from harm by maximizing anticipated benefits and minimizing possible risks of harm.

Justice requires that the benefits and burdens of research be distributed fairly.

2 HRPP Functions

2.1 Jurisdiction of the HRPP

2.1.1 Activities Overseen by the HRPP

(Revised 2/24/17)
All research or clinical investigations involving human subjects in which faculty, staff, or students acting as employees or agents of Boston Medical Center or Boston University Medical Campus are subject to the authority of the HRPP, regardless of funding source or other regulatory requirements. “Research,” “clinical investigation,” and “human subject” are defined in Section 13.

2.1.2 Equivalent Protections for Research Without Federal Oversight

(Revised 8/11/19)
The individual FWAs of Boston Medical Center and Boston University Medical Campus both apply the assurance to human subjects research with federal oversight, meaning (1) human subjects research conducted or supported by any U.S. federal department or agency that has adopted the U.S. Federal Policy for the Protection of Human Subjects (the Common Rule) and (2) clinical investigations involving products regulated by the U.S. Food and Drug Administration (FDA). For research without federal oversight, Boston Medical Center and Boston University Medical Campus have each “unchecked the box” in their FWAs, meaning that protections that differ from the Common Rule may apply. For research without federal oversight initially approved on or after February 14, 2011, Boston Medical Center and Boston University Medical Campus have established equivalent protections for approval periods (see

Sections 10.4.1.3 and 10.4.1.4.2), exempt categories (see Section 10.2.4.2.2), expedited categories (see Section 10.2.2.4.1.3), special populations (see Sections 9.2, 9.3, and 9.4), and consent for screening prior to January 21, 2019 (see Section 8.1.3.4). The requirement for single IRB review of multi-site research applies to federally-supported research (see Section 2.5.1). In all other cases, human subjects research with and without federal oversight must meet the same standards.

Studies that are not eligible for equivalent protections are:

- Studies with federal funding (including support for any researchers under a federal training grant)
  - at the time of initial approval/exempt determination; or
  - obtained after initial approval/exempt determination – the outcome letters for studies with equivalent protections include the requirement to report obtaining external funding to the IRB within 14 days of learning of the external funding; and
- Clinical investigations involving products regulated by the FDA; and
- Studies initially approved prior to February 14, 2011; and
- Studies where the sponsor or funder of the research requires adherence to the Common Rule; and
- Studies where the Boston Medical Center and Boston University Medical Campus IRB is serving as the IRB of record for an external site, unless specifically permitted by the relying institution; and
- Studies that have utilized or will utilize any clinical services.

2.1.3 Authority of the HRPP

(Revised 1/17/18)

The HRPP has the authority to:

- Approve, require changes in (to secure approval), or disapprove all non-exempt human subjects research activities and all exempt research activities requiring limited IRB review; and
- Determine that human subjects research activities meet the criteria for an exempt determination; and
- Establish training requirements for individuals involved in human subjects research activities; and
- Conduct continuing review of research at an appropriate interval and require progress reports and status check-ins from Principal Investigators; and
- Oversee the conduct of the research, including examination of research documentation and observation of the consent process; and
- Place restrictions on a study; and
- Suspend or terminate approval of research that is not being conducted in accordance with HRPP requirements, or that has been associated with unexpected serious harm to subjects, or unanticipated problems involving risks to human subjects or others.

2.2 Statutory and Regulatory Requirements for the HRPP

(Revised 6/20/18)

The HRPP is subject to regulation and inspection by both federal and state regulatory agencies, including the FDA, OHRP, and the Massachusetts Department of Public Health.

Federal regulatory requirements for HRPP operations and human research activities are:

- FDA regulations pertaining to the rights and welfare of subjects participating in research involving products regulated by the FDA, including drugs, medical devices and biological products [21 CFR Parts 50 and 56]; and
- Department of Health and Human Services regulations pertaining to rights and welfare of subjects participating in research supported with federal funding [45 CFR Part 46 (*Federal Policy for the Protection of Human Subjects*)]. Research approved or given an exempt determination prior to January 21, 2019 will continue to comply with the requirements with an effective date of July 14, 2009 in 45 CFR 46 unless the IRB makes and documents a determination that the research will comply with the requirements with an effective date of January 21, 2019 in 45 CFR 46.

State statutory and regulatory requirements for IRB operations and human research activities:

- Massachusetts General Laws Controlled Substances Act, Chapter 94C, Section 8; and

- Code of Massachusetts Regulations Title 105, Chapter 700.009; and
- Implementation of M.G.L. Chapter 94C; and
- Commonwealth of Massachusetts Fetal Research Law: General Laws, Chapter 112, Section 12J; and
- General Laws Chapter 111. Section 70G: Modified requirements for genetic testing under research subject to and conducted in accordance with review and approval of an IRB under 45 CFR Part 46 or 21 CFR Parts 50 and 56.

In the case of differences between applicable federal, state, and local laws governing the conduct of human subjects research, the legal counsels to the IRB will be consulted for guidance on resolving the conflict.

2.3 Institutional Relationships of the HRPP

2.3.1 Institutional Resources

(Revised 2/24/26)
The IOs are the FWA Signatory Officials. Each IO is a high-level institutional official who has the authority to represent the institution named in the FWA, as well as all the institutional components listed in the FWA. Entities that the Signatory Official is not authorized to represent may not be covered under the FWA. As high-level officials, the IOs promote a culture of conscience for the ethical conduct of human subjects research at the highest level within the institution, authorize necessary administrative or legal action should that be required, and ensure that the HRPP is provided with adequate resources for conducting its required functions.

For Boston Medical Center Corporation, Boston Medical Center Brighton, and Boston Medical Center South, the IO is the Vice President and Chief Scientific Officer of Boston Medical Center Health System. For Boston University Medical Campus, the IO is the Associate Vice President, Research Compliance. Both officials have sufficient standing, authority, and independence to ensure implementation and maintenance of the HRPP.

The HRPP Director and the IRB Director meet regularly with both IOs to discuss human subjects and administrative issues. The HRPP Advisory Committee (see Section 3.4.6) provides advice to the IOs and meets with them as needed. The IOs have access to minutes of convened meetings in the electronic system and are provided with a report at least monthly of IRB metrics, including a listing of all IRB actions.

As part of the oversight process, the HRPP Director is responsible for identifying any information indicating that the personnel and non-personnel resources are not well matched to the need to protect the rights and welfare of research participants by carrying out the required functions of the HRPP, including:
- IRB office functions; and
- IRB meetings; and
- HRPP educational programs; and
- HRPP compliance activities; and
- Conflict of interest identification and management; and
- HRPP quality improvement; and
- Community outreach activities.

Part of this evaluation is monitoring how appropriate the composition of the IRB office and IRB boards is in relation to that needed for review of the type and volume of research submitted. Examples of information that might indicate action is needed are significant changes in study review times, investigator satisfaction, frequency of noncompliance, or federal or institutional policies. The HRPP Director is responsible for developing a plan in response to changing needs and for initiating the process of obtaining institutional support for the changes.

2.3.2 Independence of the IRB

(Revised 10/22/18)
Human research that has been approved by the IRB may be subject to further review and approval or disapproval by the IOs or by other Boston Medical Center or Boston University officials or committees or by officials of entities that rely on the IRB. Disapprovals, restrictions, or conditions imposed by the IRB cannot be rescinded or removed by any entity other than the IRB. For research overseen by an external IRB (see Section 2.5.2.2), Boston Medical Center and Boston University may impose requirements in addition to those of the external IRB, but only the external IRB may rescind or remove any of its disapprovals, restrictions, or conditions.

IRB Chairs, IRB members, and IRB Office staff treat all individuals in the research community with equal respect and without bias based on funding success, positions of power, or any other improper factor. Investigators and research staff are not permitted to offer monetary incentives, favors, or other rewards to, or to threaten retaliation against, IRB members or IRB Office staff in connection with decisions concerning IRB submissions. Any IRB member or IRB Office staff experiencing such undue influence on their independent decision-making process from any source is encouraged to make a confidential report. This confidential report should be made to the IRB Director, or, if the source of the undue influence is the IRB Director, to the HRPP Director, or, if the source of the undue influence is the HRPP Director, to one or both IOs. The IRB Director will notify the HRPP Director and the IOs about any reports of undue influence, and the HRPP Director will notify the IOs of any reports of undue influence first reported to the HRPP Director. As appropriate, the IRB Director, the HRPP Director, or the IOs will open an investigation into the matter, which will be handled as an allegation of noncompliance according to the procedures in Section 11.4.

2.3.3 Contingency Plan

2.3.3.1 Disruptions and Recovery

(Revised 2/24/17)
Disruptions to HRPP operations may cause the HRPP to be unable to continue oversight of research studies. Disruptions may occur with varying scope, severity, and duration. The scope of the disruption may be effects on personnel, records, or both. The severity of the disruption may be partial or complete unavailability of personnel and/or records. The duration of the disruption may be hours, days, weeks, or months.

In considering the timing of recovery from a disruption, the goal is to be able to return to normal operations within a week of the beginning of the disruption. The one-week goal is appropriate for most HRPP operations (IRB review, education, and compliance). Principal Investigators are expected to submit progress reports for continuing review to the IRB well before the expiration date of the study; however, some Principal Investigators who submit less than a week before expiration may be required to cease study operations if a disruption occurs. Principal Investigators are also expected to submit well in advance of any need for IRB approval for funding purposes; however, a funding deadline may be missed if a submission was made less than a week before the deadline and a disruption occurs. Unanticipated Problems involving a fatal or life-threatening event may require actions sooner than one week after being reported to the IRB; however, the IRB response does not rely on the availability of electronic records and can be coordinated by a number of different personnel: the two IOs, the HRPP Director, the IRB Director, or one of the Chairs of the four panels. A disruption would be unlikely to render all of those individuals unavailable.

2.3.3.2 Backup and Recovery of the Electronic System

(Revised 9/26/24)
One key component of the contingency plan is availability of HRPP records. For IRB functions, the electronic system is used as the system of record, and no records that are essential to IRB oversight are maintained only in paper or only in other forms such as email correspondence.

The electronic system (both the software and the data) is backed up on a daily basis in the main Boston University Information Services & Technology (IS&T) data center on the Boston University Charles River

Campus (CRC) (“local backup”). Another backup of both the software and the database is also made on a daily basis on disk at the Massachusetts Green High Performance Computing Center (MGHPCC) (“remote backup”). The electronic system would be restored within the one-week goal.

For disruptions where the local backup has not been compromised, the process will be to have the IRB Director make the determination that restoration from the local backup is required and to have IRB staff coordinate with Boston University IS&T for the restoration of the electronic system and reconstruction of any records that were added to the system after the time of the backup.

For disruptions where backup from the remote copy on disk is required, the responsible individual at Boston University will make the determination that a disaster requiring recovery has occurred, and the IRB Director and IRB staff will coordinate with Boston University IS&T for restoration of the electronic system as well as reconstruct any records of IRB actions after the time of the backup.

2.3.3.3 Personnel Disruptions

(Revised 6/20/18)

A personnel disruption occurs when there is an unexpected lack of availability of some or all HRPP staff. Causes can include multiple resignations, epidemic diseases, natural disasters preventing personnel from traveling to work, and interruptions in electricity and/or internet service to work and/or home. If the IRB is subject to administrative actions [by FDA under 21 CFR 56.120 or 56.121 or by OHRP under 45 CFR 46.103(e) prior to January 21, 2019 or 46.103(c) on or after January 21, 2019] that include limitations on the IRB’s authority to provide oversight, this would also be considered a personnel disruption for the purposes of this contingency plan, but would be likely to be known farther in advance than other personnel disruptions.

In the specific instance where the disruption results from the inability of IRB staff and members to travel to the IRB office location, as long as electricity and internet access are available, they may use the electronic system from home and participate in convened meetings via teleconference.

To obtain external resources for responding to personnel disruptions, the HRPP will utilize the services of one or more commercial IRBs which already provide oversight for some research at Boston Medical Center and Boston University Medical Campus (see Section 7.2.2.18). For disruptions limited in scope, severity, and duration, the role of the commercial IRB will be to provide services on behalf of the Boston Medical Center and Boston University HRPP, following the policies and procedures in this document, which would not constitute transfer of oversight to the commercial IRB. Otherwise, the transfer of oversight, either temporarily or for the life of the study, will follow the FDA recommendations for transferring research oversight.

The IRB Director is responsible for identifying and responding to personnel disruptions involving IRB staff and IRB members, and the HRPP Director is responsible for identifying and responding to personnel disruptions involving other HRPP staff performing educational and compliance activities. In the situation where one of the Directors is unavailable, the other Director has both responsibilities. In the situation where both Directors are unavailable, these responsibilities transfer to the IOs, Chairs, and IRB Administrators, in that order.

As soon as a personnel disruption is identified, the responsible individual will:

- Determine the services needed to maintain oversight of research given the scope, severity, and likely duration of the disruption, including, if necessary, services needed for restoration of the electronic system; and
- Assess whether or not existing internal resources will be sufficient to provide these services; and
- If external resources are necessary:
  - Consult with the IOs to determine the funding available for obtaining external services; and
  - Contact one or more commercial IRBs to enter into an agreement for the commercial IRB to provide the necessary services; and

  - If appropriate, communicate to investigators and research staff any necessary actions on their part associated with use of the services of the commercial IRB (or include such communication in the services provided by the commercial IRB); and
  - If appropriate, communicate to OHRP, FDA, and sponsors about transfer of oversight (or include such communication in the services provided by the commercial IRB); and
- Monitor the response to the disruption to assess the impact on research oversight and adjust as necessary; and
- Determine when the disruption has resolved and as appropriate terminate any responses.

2.4 Engagement in Research

(Revised 8/11/19)

Submission to the IRB is required for all research in which a Boston Medical Center or Boston University Medical Campus constituent or entity relying on the IRB is engaged in human subjects research. Boston Medical Center or Boston University Medical Campus IS engaged in human subjects research if:

- Boston Medical Center or Boston University Medical Campus **receives a direct Federal award** through a grant, contract, or cooperative agreement for human subjects research, even where all activities involving human subjects are carried out by employees or agents of another institution; or
- Boston Medical Center or Boston University Medical Campus employees or agents:
  - intervene for research purposes with any human subjects of the research by performing invasive or noninvasive procedures or by manipulating the environment; or
  - interact for research purposes with any human subject of the research; or
  - obtain the informed consent of human subjects for the research; or
  - obtain for research purposes identifiable private information or identifiable biological specimens from any source for the research. Obtaining identifiable private information or identifiable specimens includes, but is not limited to:
    - observing or recording private behavior; or
    - using, studying, or analyzing for research purposes identifiable private information or identifiable specimens provided by another institution; or
    - using, studying, or analyzing for research purposes identifiable private information or identifiable specimens already in the possession of either institution or the investigators.

"Employees or agents" refers to individuals who act on behalf of, exercise authority or responsibility for, or perform activities designated by Boston Medical Center or Boston University.

Boston Medical Center or Boston University Medical Campus is NOT engaged in human subjects research if the involvement of their employees or agents consists only of:

- Assisting with the recruitment of subjects by:
  - informing prospective subjects about the availability of the research; or
  - providing prospective subjects with information about the research (which may include a copy of the relevant informed consent document and other IRB approved materials) but do not obtain subjects' consent for the research or act as representatives of the investigators; or
  - providing prospective subjects with information about contacting investigators for information or enrollment; or
  - seeking or obtaining the prospective subjects' permission for investigators to contact them.

    Although such recruitment activities do not constitute engagement in human subjects research, a submission to the IRB by an employee or agent to request a formal "Not Engaged" determination (see Section 10.2.6) is required when the recruitment activities involve facilitating targeted recruitment of students, trainees, or employees; direct contact with patients from Boston Medical Center or Boston University Goldman School of Dental Medicine by a member of the external research team; or the release of Protected Health Information (PHI, see Section 13 for the definition of PHI); such releases include facilitating access by the external research team to information that identifies individuals as potentially eligible for the external research study. The Boston Medical Center and Boston University Medical Campus IRB must review the

request for such releases and either approve an authorization (see Section 8.5.1) or provide a waiver of authorization (see Section 8.5.2.2).

- Obtaining coded private information or biological specimens from another institution, provided that the recipient investigators will be unable to readily ascertain the identities of the subjects to which the coded information or specimens pertain (for example, by having a written agreement prohibiting the release of the key to the code); or
- Authoring a paper, journal article, or presentation describing a human subjects research study without obtaining access to identifiable private information; or
- Accessing or using identifiable private information when visiting an institution that is engaged in the research, provided that their research activities as visitors are overseen by the IRB of the institution that is engaged in the research; or
- Performing commercial or other services for investigators provided that all of the following conditions also are met:
  - the services performed do not merit professional recognition or publication privileges; and
  - the services performed are typically performed by those institutions for non-research purposes; and
  - the institution's employees or agents do not administer any study intervention being tested or evaluated in the study; or
- Providing clinical trial-related medical services that are dictated by the study and would typically be performed as part of routine clinical monitoring and/or follow-up of subjects enrolled at a study site by clinical trial investigators, provided that all of the following conditions also are met:
  - the employees or agents do not administer the study interventions being tested or evaluated in the study; and
  - the clinical trial-related medical services are those typically provided for clinical purposes at Boston Medical Center or Boston University Medical Campus; and
  - the employees or agents do not enroll subjects or obtain the informed consent of any subject for participation in the research; and
  - when appropriate, investigators from an institution engaged in the research retain responsibility for overseeing study-related activities; and ensuring appropriate arrangements are made for reporting study-related data to investigators at an institution engaged in the research, including the reporting of safety monitoring data and adverse events as required under the IRB-approved protocol; or
- Administering the interventions being tested or evaluated in the study limited to a one-time or short-term basis, provided that all of the following conditions also are met:
  - an investigator from an institution engaged in the research determines that it would be in the subject's best interest to receive the interventions being tested or evaluated in the study; and
  - employees or agents of Boston Medical Center or Boston University Medical Campus do not enroll subjects or obtain the informed consent of any subject for participation in the research; and
  - investigators from an institution engaged in the research retain responsibility for overseeing study-related activities; ensuring the study interventions are administered in accordance with the IRB-approved protocol; and ensuring appropriate arrangements are made for reporting study-related data to investigators at an institution engaged in the research, including the reporting of safety monitoring data and adverse events as required under the IRB-approved protocol; and
  - an IRB designated on the FWA of an institution engaged in the research is informed that study interventions being tested or evaluated in the study have been administered at an institution not selected as a research site.

2.5 Multi-Site Research

2.5.1 Options for Review of Multi-Site Research

(Revised 8/11/19)

When a Boston Medical Center or Boston University Medical Campus Principal Investigator is engaged in human subjects research that is also being conducted at one or more external sites, the Boston Medical Center and Boston University Medical Campus IRB may review the research only for the local activities; may agree to act as the IRB of record for external site(s) and/or investigator(s) by entering into reliance agreements with one or more institutional IRBs or individual investigators; or may enter into a reliance agreement with an institutional, commercial, central, or single IRB for that IRB to be the IRB of record (see Section 10.2.3). The National Institutes of Health expects that grant applications and contract proposals with due dates on or after January 25, 2018 will include a plan for the use of a single IRB. The requirement that federally-supported cooperative research (projects involving more than one institution) must rely on approval by a single IRB for that portion of the research that is conducted in the United States has a compliance date of January 20, 2020.

Boston Medical Center and Boston University Medical Campus have agreed to participate in the SMART IRB Reliance Platform for single IRB review of non-exempt and exempt research and to follow the SMART IRB Standard Operating Procedures for review of multi-site research under the SMART IRB Reliance Platform.

The Boston Medical Center and Boston University Medical Campus IRB reviews research conducted at the Veterans Administration Medical Center (VAMC) when Boston Medical Center or Boston University Medical Campus is engaged in the research. When all research subjects are enrolled at the VAMC, the IRB will review the VAMC-approved consent form(s) (see Section 8.1.3.5) and the VAMC retains the oversight responsibility for any research being conducted at their facility.

2.5.2 Establishment of Oversight for Multi-site Research

2.5.2.1 Investigators at External Sites Relying on the Boston Medical Center and Boston University Medical Campus IRB

(Revised 5/26/26)

Principal Investigators submit a request for investigators at external sites to rely on the Boston Medical Center and Boston University Medical Campus IRB by providing required information about external sites in the electronic system (see Section 7.2.2.16.6). The exception to this requirement is when the request is limited to requesting that Boston University Charles River Campus rely on the Boston Medical Center and Boston University Medical Campus IRB to cover IRB oversight for Boston University Charles River Campus students who are obtaining academic credit for their participation as study staff at Boston Medical Center or Boston University Medical Campus. While these Boston University Charles River Campus student(s) are engaged on behalf of Boston University Charles River Campus, they may be added as internal study personnel (see Section 10.2.7.1), as their participation is covered by global reliance agreements between Boston Medical Center and Boston University Charles River Campus, and Boston University Medical Campus and Boston University Charles River Campus. (Note that when Boston University Charles River Campus students will not be obtaining academic credit for their participation as study staff, then Boston University Charles River Campus is not engaged in the research and thus no reliance agreement is required.)

The Principal Investigator at Boston Medical Center or Boston University Medical Campus is responsible for communications between the external sites and the Boston Medical Center and Boston University Medical Campus IRB. Specific responsibilities include:

- Obtaining the information for each relying site about local requirements, local research context issues, and local ancillary reviews that are relevant to the Boston Medical Center and Boston University Medical Campus IRB's determination to oversee the external site for research that involves interactions with subjects at an external site. Such information includes, when relevant, laws and regulations directly affecting the study; whether the sponsor requires compliance with ICH-GCP (E6); qualifications and expertise of researchers and research staff, including research workload; resources at the local research site, including space, equipment, and personnel; recruitment and consent processes; characteristics of the local population; plans to protect the

confidentiality of information; plans for the storage, handing, and dispensing of drugs and medical devices; and conflicts of interest and their management; and
- Obtaining an official signature from the relying site on an indemnification agreement that is acceptable to Boston Medical Center or Boston University, as applicable. For multi-site research with Boston University Charles River Campus, an indemnification agreement is not required if the only engaged investigators from Boston University Charles River Campus are students obtaining academic credit for their participation as study staff, or if the research is covered by a reliance agreement between Boston University Medical Campus and Boston University Charles River Campus; and
- Obtaining information from external sites necessary to make reports of Unanticipated Problems, major deviations, and safety monitors' reports with required changes or recommended changes involving subject safety (see Section 7.4.5); and
- Obtaining information needed to complete Amendments (see Section 7.4.1), Progress Reports (see Section 7.4.3.1), Status Reports (Section 7.4.3.2) and Final Reports (see Section 7.4.4); and
- Communicating IRB determinations to external sites for initial review, amendments, and continuing review, including determination letters, approved protocols, consent forms, recruitment materials, and other study documents; and
- Communicating to the IRB any questions, concerns, and suggestions from external sites about IRB processes or review.

2.5.2.2 Investigators at Boston Medical Center or Boston University Medical Campus Relying on an External IRB

(Revised 5/26/26)
Principal Investigators submit the request for another IRB to be the IRB of record by providing required information about relying on another IRB in the electronic system (see Section 7.2.2.18). An exception applies to collaborative research with Boston University Charles River Campus that falls within the scope of the global reliance agreement described in Section 2.5.2.3; no submission to the Boston Medical Center and Boston University Medical Campus IRB is required for such studies.

For non-exempt research, the consent form must be customized with information specific to Boston Medical Center and Boston University Medical Campus (see Section 8.1.3.5).

The Principal Investigator is responsible for providing the reviewing IRB with information about local requirements and local research context issues that are relevant to the reviewing IRB's determinations. The Boston Medical Center and Boston University Medical Campus IRB will assist the Principal Investigator in providing this information if necessary.

2.5.2.3 Global Reliance Agreements with Boston University Charles River Campus

(Revised 5/26/26)
Boston Medical Center and Boston University Medical Campus have established global reliance agreements with the Boston University Charles River Campus to streamline oversight of collaborative research between the institutions.

For research covered under the scope of a global reliance agreement, the reviewing IRB conducts its review and issues an approval letter. IRB staff at the reviewing IRB send the approval letter to the relying institution as confirmation of reliance. No local evaluation of the initial request to cede review is required (see Section 10.2.3.1.1).

2.5.3 Delineation of Oversight Responsibilities

2.5.3.1 Components of Reliance Agreements

(Revised 8/11/19)

Reliance on another IRB for oversight of research will be documented by a reliance agreement (also referred to as an authorization agreement) that specifies the authorities, roles, responsibilities and communications that each entity will undertake. Reliance agreements under the SMART IRB Reliance Platform will use the SMART IRB Master Common Reciprocal Institutional Review Board Authorization Agreement and will follow the SMART IRB Standard Operating Procedures. Requests to add a separate Indemnification, portal, or other agreement by an outside Institution will be reviewed by the Office of the General Counsel of either Boston Medical Center or Boston University and will be signed by the respective institution's authorized signatory.

The use of the SMART IRB platform is preferred; however, other reliance agreements are possible. These must have, at a minimum, the following components:

- The names, FWA numbers, and IRB Registration numbers of the reviewing IRB and the relying institution; and
- Identification of the specific study or types of studies covered by the agreement. For specific studies, the identification includes the study title, IRB number, Principal Investigator, and funding source; and
- A statement that the review and continuing oversight provided by the reviewing IRB will meet the requirements of the FWA(s) of the relying institution and that the relying IRB remains responsible for ensuring compliance with its own FWA(s); and
- A statement concerning who will make determinations for use and disclosure of PHI for research under 45 CFR 512(i) (see Section 8.5.2.2).; and
- A statement that the reviewing IRB will make relevant IRB records (including minutes of IRB meetings, determination letters, and approved protocols, consent forms, and other study documents) available to the relying institution upon request; and
- A statement that each institution is responsible for assuring that all of their research personnel have adequate education, training and qualifications to perform the research and safeguard the rights and welfare of research subjects; and
- A statement that each institution is responsible for maintaining polices regarding the disclosure and management of research personnel conflicts of interest related to research, that the relying institution will communicate to the reviewing IRB any conflict of interests and applicable management plans, and that the reviewing IRB has the authority to determine whether any additional management is required for disclosed conflicts of interest; and
- A statement that each institution is responsible for assuring that all other internal reviews (e.g., Institutional Biosafety, Radiation Safety) have been completed and that determinations of these reviews are communicated to the reviewing IRB; and A statement that the relying institution will inform the reviewing IRB of any additional institutional or regulatory requirements pertinent to the IRB review: and
- A statement that the relying institution will cooperate with a request from the reviewing IRB for a for-cause audit of the research being reviewed; and
- A statement concerning the capabilities of the relying institution to perform audits; and
- Arrangements for communication between the IRBs/institutions and reporting to OHRP and FDA as appropriate concerning Unanticipated Problems, suspensions, terminations, and serious or continuing noncompliance; and
- The process by which participation in the reliance agreement may be terminated, including provisions for continued oversight of active studies; and
- The names, institutional titles, and contact information for the institutional signatory officials and the institutional point of contact for the reliance agreement; and
- The signatures and dates signed of the signatory individuals.

2.5.3.2 Retained and Ceded Responsibilities

(Revised 6/28/24)

The responsibilities retained by the Boston Medical Center and Boston University Medical Campus HRPP when relying on an external IRB include:

- Evaluation of requests to cede review (see Section 10.2.3.1); and

- Determinations that the study meets the requirements for waivers of HIPAA authorization for research uses and disclosures of subjects' PHI as defined in the HIPAA regulations for PHI released from BMC or BU for studies submitted on or after September 1, 2019 (see Section 8.5.2.2); and
- Conflict of interest reporting and evaluation: Investigators are required to report their financial interests according to Section 6.5.1, and Boston Medical Center and Boston University are responsible for evaluating whether the interests constitute Financial Conflicts of Interest that require management according to Section 6.5.2, and for communicating. management plans to the reviewing IRB; and
- Reviews performed by special routing (see Section 7.2.2.2); and
- Monitoring research: The compliance provisions of Section 11 apply to all human subjects research conducted by Boston Medical Center and Boston University Medical Campus investigators and research staff, including those where another IRB is acting as the IRB of record. For QA Reviews (see Section 11.3.8), the QA Review Report will inform the study team which findings are reportable to the IRB of record and in addition, a summary of reportable findings will be provided to the IRB of record. For targeted audits (see Section 11.3.10), the Boston Medical Center and Boston University Medical Campus HRPP will notify the IRB of record of any potential noncompliance with applicable human subjects protection regulations or with the requirements or determinations of the IRB of record; and
- Investigator qualifications: The process for ceding review includes providing training for investigators and research staff (see Section 6.4) and assuring that all study staff meet the qualifications and training requirements in Section 6.2.3, including personnel added to the study after initial approval; and
- Organizational conflicts of interest: Boston Medical Center and Boston University are responsible for notifying the external IRB of any organizational conflicts of interest

The responsibilities ceded to the IRB of record when the Boston Medical Center and Boston University Medical Campus HRPP relies on an external IRB include:

- Performing the scientific review of the protocol; and
- Ensuring concordance between any applicable grant and the protocol; and
- Reviewing potential noncompliance, including complaints, protocol deviations, and results of audits and making determinations of noncompliance according to the policies and procedures of the IRB of record; and
- Evaluating the protections provided by management plans for conflicts of interests and imposing additional requirements if necessary to protect the rights and welfare of subjects; and
- Obtaining any additional approvals from DHHS when the research involves pregnant persons, fetuses, and neonates; or children; or prisoners; and
- Reporting to regulatory agencies and sponsors concerning serious or continuing noncompliance, unanticipated problems, and suspensions or terminations of IRB approval. The IRB of record is expected to provide the Boston Medical Center and Boston University Medical Campus HRPP the opportunity to review and comment on the report before it is sent to regulatory agencies or sponsors.

2.5.4 Principal Investigator Reporting Requirements in Multi-Site Research

(Revised 9/16/26)

If the Boston Medical Center and Boston University Medical Campus IRB reviews the research, the Principal Investigator must submit all amendments, Progress Reports, Final Reports, protocol exceptions, Unanticipated Problems, and deviations to the Boston Medical Center and Boston University Medical Campus IRB for review and approval.

If the Boston Medical Center and Boston University Medical Campus IRB has entered into a reliance agreement with another IRB that acts as the IRB of record, the Principal Investigator must comply with all reporting requirements of the IRB of record. In addition, the Principal Investigator must:

- Submit Internal Study Personnel Changes to the Boston Medical Center and Boston University Medical Campus IRB for administrative approval (see Section 7.4.1.1); and

- Submit Amendments (see Section 7.4.1.2) when required as described in Section 10.2.3.1.2; and
- Submit Reportable Events and New Information forms (see Section 7.4.5) to report any changes made to eliminate an apparent immediate hazard to subjects that occur at Boston Medical Center or Boston University Medical Campus site ("internal immediate apparent hazards to subjects"). This requirement is in addition to required reporting to the IRB of record according to its reporting requirements for changes made to eliminate an apparent immediate hazard to subjects; and
- Submit Reportable Events and New Information forms (see Section 7.4.5) to report any serious and/or continuing noncompliance determinations or Unanticipated Problem determinations made by the reviewing IRB in relation to event(s) that occur at the Boston Medical Center or Boston University Medical Campus site ("internal serious and/or continuing noncompliance" and "internal Unanticipated Problems" according to Section 6.6.3.2). This form must be submitted to the IRB as soon as possible but no later than 7 calendar days of the investigator or research staff becoming aware of the serious and/or continuing noncompliance determination or Unanticipated Problem determination made by the reviewing IRB; and
- Submit a Status Check-In Report form prior to the status check-in due date (see Section 10.4.1.5); and
- Submit a Final Report after the IRB of record closes the study (see Section 6.6.6 and Section 7.4.4).

2.6 International Research

(Revised 6/29/17)
Research conducted outside the United States under Boston Medical Center's FWA or Boston University Medical Campus's FWA must comply with the conditions of those FWAs and all HRPP policies and procedures.

Each international study conducted under the Boston Medical Center or Boston University Medical Campus FWA must have a Boston Medical Center or Boston University Medical Campus Principal Investigator who is accountable to the IRB for the conduct of the research.

The IRB reviews the submission for appropriate local context to ensure that the research meets equivalent levels of participant protection, taking the cultural context into account. The IRB evaluates whether:

- Subjects are protected from unnecessary or unjustified risks throughout the course of the study; and
- Selection of subjects is equitable; and
- Privacy of subjects is protected and confidentiality of data is maintained; and
- Informed consent is sought in language understandable to the subject and under conditions that minimize the possibility of coercion or undue influence; and
- Informed consent is documented in a culturally appropriate manner; and
- Appropriate safeguards are in place to protect the rights and welfare of vulnerable subjects.

The IRB may base this evaluation on review from a local IRB, in which case the Principal Investigator must provide information on the qualifications of that IRB. For minimal risk studies where local IRB review is not required, the IRB may accept the necessary information about the local research context from an appropriate consultant, who is not an investigator on the project or the grant, who has no other conflict of interest, and who has knowledge of local context obtained through extended, direct experience with the specific subject populations and their surrounding communities. The Principal Investigator must provide information about the identity and qualifications of the consultant and a written attestation from the consultant that they have reviewed the research and agree that the six points above have been met. The attestation must be signed or sent from the consultant's individual email address. The Principal Investigator may describe an alternate plan for obtaining local context review, explaining how this alternate plan protects subjects.

Principal Investigators must provide the required information for submissions involving international research as described in Section 7.2.2.16.1.

The Boston Medical Center or Boston University Medical Campus researcher is responsible for knowing and complying with any laws, regulations, permission requirements, or policies in the host country. This includes any requirements for drug studies such as manufacturing, distribution, storage, and administration of the drug. Principal Investigators are expected to consult OHRP guidance at http://www.hhs.gov/ohrp/international/index.html.

2.7 Interactions with Research Subjects and Communities

2.7.1 Current, Prospective, and Past Research Subjects

(Revised 5/3/25)

The Office of the IRB provides a point of contact for current, prospective, and past research subjects and their family members. Contact information for the IRB is included in all consent forms and on the IRB website. Records of subject communications are maintained by the Office of the IRB.

The phone number (including voicemail) and email for the IRB are monitored during normal business hours by IRB Office staff. Staff refer communications from current, prospective, or past research subjects to the IRB Director, or to their designee among the IRB Office staff if the IRB Director is unavailable. If the communication is a simple request for information about participating in research, the subject's questions will be answered and the subject will be referred to the resources described in Section 2.7.2. If the communication is a concern or complaint about a particular study, the IRB Director or designee ascertains the nature of the subject's concern and follows up with the Principal Investigator, other research staff, members of the HRPP, and other institutional officials as warranted. If the subject has requested confidentiality, the IRB Director or designee will not reveal the subject's identity. When the subject's issue should be resolved by the Principal Investigator, the IRB Director or designee will communicate regularly with the Principal Investigator to monitor the progress of the resolution. If the subject's issue involves noncompliance, the procedures described in Section 11.4 will be followed. Subjects who are not satisfied with the response of the Principal Investigator and/or IRB will be informed of their ability to contact the IOs, OHRP, and/or the FDA.

The IRB Director monitors and tracks all instances of outreach to the IRB by subjects or prospective subjects to identify any trends or patterns that suggest areas for improvements or areas of noncompliance. This analysis is done annually and communicated to the HRPP Director as part of the HRPP quality improvement process.

2.7.2 Community Outreach and Education

(Revised 5/3/25)

The HRPP partners with the Boston University Clinical and Translational Science Institute (BU CTSI) and the Boston Medical Center Clinical Research Network (BMC CRN) in educating the community about human subjects research and opportunities to be involved in research. The home pages on the OHRA website prominently display links to pages "For Research Participants" and "For Community Members." The pages for research participants include contact information for the IRB, the research subjects' Bill of Rights, Frequently Asked Questions, a glossary of research terms, access to the BMC CRN Research Learning Center, and ways to learn more. The pages for community members include how to get involved (for example, by becoming a trained research advocate, by participating in a research study, and by serving on the IRB), why to get involved, a Community Events Calendar, community engagement updates, and information about Boston Medical Center, Boston University Medical Campus, and the community engagement activities of the BU CTSI, including evaluation of the community outreach and education program. As part of this partnership with the BMC CRN and BU CTSI, the HRPP collaborates on ways to conduct community outreach and facilitate community-engaged research. The HRPP works with the BU CTSI and BMC CRN to offer educational seminars and hands-on workshops focused on

community engagement strategies, experiences, and best practices (see Section 6.4.3). The schedule of presentations and workshops is evaluated on an ongoing basis by the CRRO Director and HRPP Director, and the quality of each presentation is evaluated using an anonymous survey. The evaluation surveys also solicit ideas for future topics. The results are communicated to the presenters and used to guide upcoming offerings. The Executive Board (see Section 10.2.1.7) is also empowered to review and approve materials used in community outreach, such as template informational brochures disseminated to prospective subjects and the community. Executive Board approval of such materials is documented in meeting minutes (see Section 5.7).

2.7.3 Community Engaged Research

(Revised 2/24/17)
The HRPP encourages investigators, when appropriate, to design research projects that promote the involvement of community members in the design and implementation of research and the dissemination of results. When evaluating such studies according to the criteria described in Section 10, the IRB will assess whether the design of the community engagement component minimizes risks, including possible risks of group harms. The Boston HealthNet Research Subcommittee provides resources for investigators planning community engaged research projects involving the affiliated Boston HealthNet community health centers.

If a study involves community members helping to implement research, such as obtaining consent or gathering or analyzing identifiable data, these community members are considered to be engaged in research. The Principal Investigator of such a study may plan to use an alternative Human Research Protection training program for these community members, such as training through Harvard Catalyst, the Community-Campus Partnerships for Health, or the Office of Research Integrity (see Section 6.2.3.1).

3 Structure of the Boston Medical Center and Boston University Medical Campus Institutional Review Board

3.1 IRB Boards

(Revised 2/24/17)
The IRB comprises four internal review panels and an Executive Board. The term “IRB board” refers to one of the panels or to the Executive Board. The IRB does not use subcommittees for review.

3.2 IRB Composition

(Revised 8/11/19)
The IRB boards have at least five members with varying backgrounds to promote complete and adequate review of the research conducted at Boston Medical Center and Boston University Medical Campus. Members come from multiple professions, and represent diverse cultural backgrounds and all genders. The IRB includes members with knowledge of institutional commitments and requirements, the local community, local research, local context, and experience with subjects likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons. At least one member of the IRB is a nursing representative who is a Boston Medical Center Educator/Professional Registered Nurse. At least one member of each IRB board is a scientist, at least one member is a non-scientist, and at least one member is unaffiliated. Members are considered non-scientists when their primary professions or areas of interest are in nonscientific areas. Members are considered unaffiliated when neither they nor any immediate family member is an employee or student at Boston Medical Center or Boston University. Unaffiliated members are considered to represent the perspective of research participants. According to quorum requirements (see Section 5.6), at least one non-scientist must be present at each meeting. The expectation is that at least 75% of meetings will have one or more unaffiliated members present. The IRB Director will include in the annual review of IRB composition (see Section 3.3.1) whether this expectation

is being met and if necessary will make adjustments by counseling unaffiliated members about their attendance, and/or by replacing and/or adding unaffiliated members.

The affiliated members of the Executive Board include the HRPP Director, the Chairs and Vice Chairs of each panel, the IRB Director, the Associate Director of the Office of Human Research Affairs, the nursing representative designated by the Boston Medical Center Chief Nursing Officer, and the Boston Medical Center Research Compliance Officer. The HRPP Director serves as Chair of the Executive Board; in the absence of the HRPP Director, the IRB Director or any of the Chairs or Vice Chairs of each panel may serve as the Chair of the Executive Board.

The IRB Director maintains a roster of IRB members identified by name, earned degrees, representative capacity, indications of experience sufficient to describe each member's chief anticipated contribution to IRB deliberations, and affiliation. The IRB Director also maintains a membership list that is posted on the IRB website listing the members' names, affiliations, and board roles.

Voting IRB members may be designated as being able to serve as an alternate to vote for voting members who are not present at a meeting. Each IRB member is designated in one of three representative categories (medical/dental-scientist, non-medical/dental scientist, non-scientist). Any member from any panel or from the alternate list can serve as an alternate for any other voting member as long as both members are listed in the same category.

The IRB has an IRB Internship program where trainees spend two months attending IRB meetings as part of their learning experience. Trainees/IRB interns serve as IRB reviewers, under the mentorship of experienced IRB members. Trainees are not members of the IRB and do not vote.

3.3 IRB Members

3.3.1 Selection and Appointment of IRB Members

(Revised 6/20/18)
IRB Chairs, with the IRB Director, determine the types of expertise required for review of research conducted by their panels. On an annual basis, as part of the evaluation of IRB members (see Section 3.3.5), the IRB Director will assess the composition of the panels and the actual attendance at meetings to determine whether any adjustments are necessary. Department Chairs, IRB administrative staff, board members and others may nominate potential IRB members to the IRB Director.

Individuals who are responsible for business development at Boston Medical Center or Boston University, such as members of grant administration, technology development, finance, or clinical trial offices, are considered to have a potential organizational financial conflict of interest and thus may not serve as IRB members or carry out day-to-day operations of the review process.

The IRB Director is responsible for the appointment of new IRB members. The IRB Director informs the HRPP Director and the IOs of changes in IRB membership. New members are added to the roster and to the posted membership list within one week of any updates to the membership. The IRB Director will submit roster changes to OHRP in the IRB Registrations as required prior to January 21, 2019.

Orientation of new IRB members is primarily the responsibility of the IRB Director with the assistance of Board Chairs, Vice Chairs, and experienced IRB members.

3.3.2 Length of Term/Service of IRB Members

(Revised 9/15/20)
There is no set term limit for how long an IRB member may serve on the IRB. Appointments to the IRB are made by the IRB Director biennially for a two-year term. The IRB Director will consider an IRB member's biennial evaluation (see Section 3.3.5) in assessing the biennial re-appointment of the IRB member.

3.3.3 Duties of IRB Members

(Revised 2/24/17)
IRB members are responsible for ensuring that the rights and welfare of research subjects are protected by reviewing and approving human research in a manner consistent with federal regulations, state and local laws, and institutional guidelines and policies. IRB members attend IRB meetings and may be assigned as primary or secondary reviewers. When assigned as a reviewer for a submission to be reviewed at a convened IRB meeting, IRB members are expected to submit their reviews prior to the IRB meeting in the electronic system.

3.3.4 Attendance Requirements for IRB Members; Alternate Members

(Revised 6/29/17)
Members attend their respective meetings, where attendance is noted in the IRB minutes. Voting board members may serve as alternates for other voting board members in the same category (Chair, medical/dental-scientist, non-medical/dental scientist, non-scientist). A voting member may only substitute for another member of any panel if such IRB member is not available to vote (e.g.; absent, recused for conflict of interest). If more than one alternate member is present at a meeting where members are not present, only one alternate may vote for each absent member. The IRB staff members assigned to each meeting are responsible for tracking alternates and ensuring that IRB business only takes place when there is a quorum present (see Section 5.6).

Expectations for attendance of unaffiliated members are described in Section 3.2.

3.3.5 Evaluation of IRB Members

(Revised 4/18/21)
The performance on the IRB of IRB members who are not also IRB staff members will be evaluated every two years by the Chair of their panel (or the Chair most familiar with their work if they are members of more than one panel). The IRB members who are eligible for re-appointment will be given a summary of their attendance and reviews and be asked to perform a self-evaluation of their IRB performance and knowledge. The Chair will designate an IRB staff member who is familiar with the IRB member to provide a confidential evaluation of the IRB member's IRB performance and knowledge. The Chair will review the self-assessment and staff assessment and prepare a narrative highlighting the IRB member's strengths and areas for improvement. The narrative will be provided in writing to the IRB member unless significant problems are identified, in which case feedback will be provided in a face-to-face meeting with the Chair. The IRB member may request a face-to-face meeting with the Chair upon receipt of the narrative.

3.3.6 Removal/Replacement of IRB Members

(Revised 2/24/17)
IRB members may be removed or replaced by the Chair of their panel in collaboration with the IRB Director. Members who have questions or concerns about their removal are encouraged to have a confidential discussion with the HRPP Director or with one or both IOs.

3.4 Leadership and Staff

3.4.1 Chairs

3.4.1.1 Selection and Appointment of Chairs

(Revised 1/17/18)
The IOs appoint a Chair for each IRB panel, in consultation with the HRPP Director and/or the IRB Director. The Chairs' names and credentials are maintained by the IRB Director in the IRB roster.

3.4.1.2 Length of Term of Chairs

(Revised 9/15/20)
There is no set term limit for how long the Chair may serve as IRB Chair. Appointments are made every two years by agreement of both IOs for a two-year term. The IOs will consider a Chair's biennial evaluation (see Section 3.4.1.4) in assessing the re-appointment of the Chair.

3.4.1.3 Duties of Chairs

(Revised 5/30/17)
The Chairs direct their panel's proceedings in accordance with institutional and federal requirements, as well as parliamentary procedure. They work closely with the IRB Director, Board Members, IRB Administrators, IRB Analysts, other IRB Office staff, the HRPP Director, IOs, investigators, and research staff to ensure that the rights and welfare of research subjects are protected. The IRB Chairs review and approve the minutes of each IRB meeting they conduct and are responsible for the annual evaluations of IRB members and Vice Chairs on their panels (see Sections 3.3.5 and 3.4.2.4, respectively) and of the IRB Director (see Section 3.4.4.4).

The Chairs review protocol exceptions according to Section 10.2.2.4.2.2. The Chairs conduct expedited review according to Section 10.2.2.4 and designate experienced IRB members as expedited reviewers according to Section 10.2.2.1. Chairs serve as members of the Executive Board (see Section 3.2) and of the HRPP Advisory Committee (see Section 3.4.6.1). Chairs evaluate requests to cede review according to Section 10.2.3. Chairs assist with the evaluation of interventions continuing after study expiration (see Section 6.6.2.1.5.2), unanticipated problems and major deviations (see Section 10.2.1.4), and potential researcher noncompliance (see Section 11.4.3.4).

3.4.1.4 Evaluation of Chairs

(Revised 9/15/20)
The performance on the IRB of Chairs will be evaluated every two years by the IRB Director. Chairs will be given a summary of their attendance and reviews over the past two years and be asked to perform a self-evaluation of their IRB performance and knowledge. The IRB Director will designate an IRB staff member who is familiar with the Chair to provide a confidential evaluation of the Chair's IRB performance and knowledge. The IRB Director will review the Chair's self-assessment and staff assessment and prepare a narrative highlighting the Chair's strengths and areas for improvement. The narrative will be provided in writing to the Chair unless significant problems are identified, in which case feedback will be provided in a face-to-face meeting with the IRB Director. The Chair may request a face-to-face meeting with the IRB Director upon receipt of the narrative.

3.4.1.5 Removal/Replacement of Chairs

(Revised 2/24/17)
Chairs may be removed or replaced at any time by the agreement of the IOs.

3.4.2 Vice Chairs

3.4.2.1 Selection and Appointment of Vice Chairs

(Revised 1/17/18)
The IOs may select and appoint one or more Vice Chairs for the IRB panels, in consultation with the panel Chair, the HRPP Director, and/or the IRB Director. The Vice Chairs' names and credentials are maintained by the IRB Director in the IRB roster.

3.4.2.2 Length of Term of Vice Chairs

(Revised 9/15/20)
There is no set term duration for the Vice Chair's appointment. Appointments are made very two years by agreement of both IOs for a two-year term. The IOs will consider a Vice Chair's biennial evaluation (see Section 3.4.2.4) in assessing the re-appointment of the Vice Chair.

3.4.2.3 Duties of Vice Chairs

(Revised 2/24/17)
The Vice Chair shares the same functions and duties as the Chair, as delegated by the Chair (see Section 3.4.1.3).

3.4.2.4 Evaluation of Vice Chairs

(Revised 9/15/20)
The performance on the IRB of Vice Chairs will be evaluated every two years by the Chair of their panel. Vice Chairs will be given a summary of their attendance and reviews over the past two years and be asked to perform a self-evaluation of their IRB performance and knowledge. The Chair will designate an IRB staff member who is familiar with the Vice Chair to provide a confidential evaluation of the Vice Chair's IRB performance and knowledge. In addition, the Chair will ask the IRB Director for feedback on the Vice Chair's performance in chairing panel meetings, if the Vice Chair has done so in the past two years. The Chair will review the self-assessment and staff assessment and prepare a narrative highlighting the Vice Chair's strengths and areas for improvement. The narrative will be provided in writing to the Vice Chair unless significant problems are identified, in which case feedback will be provided in a face-to-face meeting with the Chair. The Vice Chair may request a face-to-face meeting with the Chair upon receipt of the narrative.

3.4.2.5 Removal/Replacement of Vice Chairs

(Revised 2/24/17)
Vice Chairs may be removed or replaced at any time by the IOs.

3.4.3 HRPP Director

3.4.3.1 Selection and Appointment of the HRPP Director

(Revised 12/20/20)
The HRPP Director is selected and appointed by the IOs. The individual performing the functions of HRPP Director as outlined in this document is an official of Boston Medical Center or Boston University with appropriate experience, training, and background to oversee the HRPP.

3.4.3.2 Length of Term of the HRPP Director

(Revised 9/28/16)
There is no set term duration for the HRPP Director.

3.4.3.3 Duties of the HRPP Director

(Revised 8/11/19)
The HRPP Director provides leadership and oversight for the HRPP. The HRPP Director is responsible for maintaining the written plan for the HRPP (see Section 1.2); providing a written rationale and approval for exceptions to policies and procedures for research oversight activities (see Section 1.2); leading the HRPP Quality Improvement process (see Section 1.3.2); preparing the HRPP budget (see Section 2.3.1); chairing the HRPP Advisory Committee (see Section 3.4.6) and the Executive Board (see Section 3.2); reporting Unanticipated Problems, serious or continuing noncompliance, and suspension or termination of approval (see Section 10.7); reporting negative actions or press coverage (see Section 10.8); and overseeing compliance activities (see Section 11). The IOs may delegate to the HRPP Director the responsibility to sign IRB Authorization Agreements, Collaborating Institutional Investigator Agreements, and Individual Investigator Agreements (see Section 3.4.7).

3.4.3.4 Evaluation of the HRPP Director in the Role of IRB Member

(Revised 2/24/17)
The HRPP Director will normally not be an IRB Member, unless the HRPP Director is also the IRB Director, in which case the evaluation described in Section 3.4.4.4 will be performed.

3.4.3.5 Removal/Replacement of the HRPP Director

(Revised 2/24/17)
The HRPP Director can be removed or replaced by the Director of the Office of Human Research Affairs or by the IOs.

3.4.4 IRB Director

3.4.4.1 Selection and Appointment of the IRB Director

(Revised 2/24/17)
The IRB Director is selected and appointed by the HRPP Director. The IRB Director is designated as the Human Protections Administrator on each FWA. The IRB Director reports to the HRPP Director.

3.4.4.2 Length of Term of the IRB Director

(Revised 9/28/16)
There is no set term duration for the IRB Director.

3.4.4.3 Duties of IRB Director

(Revised 8/11/19)
The IRB Director serves as a regulatory consultant to the IRB Chairs, Vice Chairs, and IRB members. The IRB Director has regulatory oversight responsibilities for the IRB and the IRB Office and is responsible for updating and renewing the FWAs and IRB registrations (see Sections 1.1 and 3.2); providing a written rationale and approval for exceptions to policies and procedures for IRB activities (see Section 1.2); responding to subject concerns (see Section 2.7.1), appointing and training new board members (see Section 3.3.1), performing the annual evaluations of Chairs (see Section 3.4.1.4) and IRB Office staff (see Section 3.4.5.2) and leading the evaluation of requests to cede review (see Section 10.2.3). The IRB Director is a member of the HRPP Advisory Committee (see Section 3.4.6.1) and the Executive Board (see Section 3.2). The IOs may designate to the IRB Director the responsibility to sign IRB Authorization Agreements, Collaborating Institutional Investigator Agreements and Individual Investigator Agreements (see Section 3.4.7).

3.4.4.4 Evaluation of the IRB Director in the Role of IRB Member

(Revised 9/15/20)
The performance on the IRB of the IRB Director as a voting member, if applicable, will be evaluated every two years by one of the IRB Chairs. The Chairs will consult one another to designate the individual who will evaluate the IRB Director. The IRB Director will be given a summary of their attendance and reviews over the past two years and be asked to perform a self-evaluation of their IRB performance and knowledge. The Chair will designate an IRB Office staff member to provide a confidential evaluation of the IRB Director's performance and knowledge as a voting IRB member. The Chair will review the self-assessment and staff assessment, consult with the HRPP Director and IOs, and prepare a narrative highlighting the IRB Director's strengths and areas for improvement. The narrative will be provided in writing to the IRB Director unless significant problems are identified, in which case feedback will be provided in a face-to-face meeting with the Chair. The IRB Director may request a face-to-face meeting with the Chair upon receipt of the narrative.

3.4.4.5 Removal/Replacement of the IRB Director

(Revised 2/24/17)
The IRB Director can be removed or replaced by the HRPP Director in consultation with the IOs.

3.4.5 IRB Administrative Staff

3.4.5.1 Selection and Appointment of IRB Administrative Staff

(Revised 2/24/17)
The IRB Director is responsible for the hiring of all IRB Office staff (including Administrative Assistants, Application Administrators, IRB Coordinators, IRB Analysts, and IRB Administrators). The IRB Director may delegate this responsibility to a senior member of the IRB Office staff as appropriate.

The IRB Director will appoint IRB Office staff as alternate board members as appropriate based on their experience and knowledge. The IRB Director will communicate their recommendation that a board member who is a member of the IRB Office staff qualifies as an Expediter to the Chair of the staff member's panel according to Section 10.2.2.1.

3.4.5.2 Evaluation of IRB Staff who are IRB Members

(Revised 1/17/18)
IRB staff are evaluated annually by the IRB Director. IRB staff who are also IRB members will have evaluation of their performance as IRB members incorporated into their annual performance review.

3.4.5.3 Removal/Replacement of IRB Administrative Staff

(Revised 7/25/16)
IRB Administrative staff report to the IRB Director or (as designated) to a senior member of the IRB Administrative Staff. There is no set term limit for IRB Administrative Staff. The IRB Administrative Staff can be removed or replaced by the IRB Director in accordance with Boston University Human Resource policies.

3.4.5.4 Duties of IRB Administrative Staff

(Revised 6/30/16)
The duties of the IRB Administrative Staff are specified in their job descriptions and described in Section 4.1 of these policies.

3.4.6 HRPP Advisory Committee

3.4.6.1 Composition of the HRPP Advisory Committee

(Revised 8/11/19)
The voting members of the HRPP Advisory Committee are the Chairs, the Vice Chairs, the HRPP Director, the IRB Director, the Associate Director of the Office of Human Research Affairs, the nursing representative designated by the Boston Medical Center Chief Nursing Officer, and the Boston Medical Center Research Compliance Officer. Non-voting members are the legal consultants to the IRB from Boston Medical Center and Boston University, the Privacy Officers of Boston Medical Center and Boston University, and the CRRO Director. The HRPP Director serves as the Chair of the HRPP Advisory Committee. The IRB Director or any of the Board Chairs or Vice Chairs may serve as an Alternate Chair.

3.4.6.2 Responsibilities of the HRPP Advisory Committee

(Revised 4/25/16)
The HRPP Advisory Committee provides leadership to the HRPP program, by reviewing and making recommendations to the IOs concerning policies and procedures. In addition, the HRPP Advisory Committee provides a forum for discussions of regulatory interpretation, and to assure consistency among panels.

3.4.7 The Institutional Officials (IOs)

(Revised 8/11/19)
The IOs must be legally authorized to represent the institution providing the FWA (see Section 2.3.1). The IOs may not be the Chair or a voting member of any of the IRB boards. The IOs sign IRB Authorization Agreements, Collaborating Institutional Investigator Agreements and Individual Investigator Agreements for their respective institutions but may delegate this responsibility to the HRPP Director, the IRB Director or one of the Board Chairs.

3.5 Training of IRB Chairs, Vice Chairs, and Members

3.5.1 Orientation

(Revised 6/29/17)
IRB Chairs, Vice Chairs and members are provided with orientation materials as well as ongoing educational training materials. Orientation materials include, the Belmont Report, Department of Health and Human Services Protection of Human Services regulations 45 CFR 46, FDA regulations 21 CFR 50 and 56, the OHRP expedited review procedure, Boston Medical Center and Boston University Medical Campus HRPP Policies and Procedures, instructions on the use of the electronic system, and additional resource materials. In some cases written materials may be substituted with on-line links to these documents. In addition, new members are individually oriented by the IRB Educator (or a designated experienced board member or IRB Staff member). New board members attend at least one IRB meeting as an observer before voting at a meeting. New board members attend at least two meetings as a voting board member before being assigned as a primary or secondary reviewer. The IRB Educator or an experienced board member serves as a mentor for the new board member at least for their first formal review as a primary or secondary reviewer.

Experienced, voting Board Members may be designated by one or more Chairs to review submissions via the expedited review procedure. These board members are referred to as Expediters. Experienced IRB staff may serve as Expediters. All Expediters receive additional training related to the expedited review procedure by the IRB Director or designee.

3.5.2 Continuing Education for Board Members

(Revised 2/24/17)
Brief board education sessions are regularly provided to board members by the IRB Director (or designee) at the start of the IRB meetings. The annual evaluation of board members (see Section 3.3.5) will be used to identify areas for continuing education of board members. The continuing education sessions cover general research related topics, regulatory issues, study specific questions, or the most recent topic of the CR Times feature article. IRB members are also strongly encouraged to read the CR Times each month. (The Clinical Research Times is a monthly on-line newsletter published by the Office of Human Research Affairs. Copies may be found at www.bu.edu/crtimes) Board members are also invited to attend the Clinical Research Seminar Series, a monthly seminar sponsored by the Office of Human Research Affairs.

3.5.3 Reference Materials

(Revised 2/24/17)
Reference materials may be found in the IRB office or specific URL links located on the IRB website. These links include the OHRP website, FDA website, and other related IRB and human research protection websites. The IRB website may be accessed by investigators, research staff, IRB staff, and IRB members via the internet.

3.6 Compensation of IRB Members

(Revised 2/24/17)

IRB members who are affiliated with Boston Medical Center or Boston University are not compensated for their work on the IRB. Unaffiliated IRB members are provided with an honorarium as arranged by the IRB Director. The Chairs and Vice Chairs are compensated through funding given directly to them or through their departments. Some compensation may be provided to IRB members at the discretion of the IRB Director under special circumstances such as performing review of expedited and exempt submissions. IRB members may be reimbursed for some expenses related to their IRB participation such as parking.

3.7 Liability Coverage for IRB Members

(Revised 3/21/17)
IRB member liability is covered by the Boston University and the Boston Medical Center insurance policies. Upon request, a member will be provided with an indemnification letter from each institution.

3.8 Use of Consultants

(Revised 2/24/17)
IRB boards use non-member consultants for advice and information in specialized areas as needed (see Section 10.2.1.2). These consultants may be Boston Medical Center clinicians or Boston University faculty, staff, or students, or may be unaffiliated with Boston Medical Center or Boston University. The IRB Director is responsible for arranging for the use of formal consultants. The formal consultants may be asked to present their assessments in writing or to attend IRB meetings in person or by phone. Consultants do not vote during IRB meetings and are bound by the same confidentiality and conflict of interest disclosure requirements as all other attendees at an IRB meeting. In addition, IRB members may directly contact non-member colleagues for information that would be helpful for their reviews; in this case, the IRB member will remind the colleague of confidentiality obligations and will document in the electronic system that an informal consultation took place.

3.9 IRB Member Conflict of Interest Policy

(Revised 6/29/17)
To assure that reviews of IRB submissions are conducted with objectivity and in a manner designed to ensure the exercise of independent judgment, consultants may not review and IRB members may not vote on actions concerning projects or activities in which they have a conflict of interest as defined below.

A conflict of interest is considered to exist for an IRB member or consultant if:

- The IRB member, consultant, or immediate family member is a Principal Investigator, Supervising Principal Investigator (formerly known as Faculty Sponsor), or co-investigator, or is otherwise involved in the design, conduct, or reporting of the research; or
- The IRB member, consultant, or immediate family member has any financial interest in the sponsor, product, or service being tested.

“Immediate family member” refers to a spouse or dependent child. “Financial interest” refers to anything of monetary value, including a salary, consulting fee, honorarium or other payment for service; equity interests, including stocks, stock options or other ownership interests; and intellectual property rights, including patent rights owned by the IRB member, consultant or immediate family member or on which a IRB member, consultant, or immediate family member is a named inventor (whether licensed or not), copyrights and royalties.

All IRB members are responsible for making any conflict of interest known to the IRB Chair and recusing themselves from the portion of the meeting during which final discussion and voting on the submission in question occurs. Knowing failure to abide by these requirements may be cause for removal of a member from the IRB.

Depending on the nature of the conflict, the member who has identified the conflict may be allowed to participate in the IRB discussion to provide the IRB with information about the research prior to the final discussion and voting on the submission. This is done at the discretion of the meeting Chair. The fact that

a research proposal is submitted by another investigator from an IRB member's Department or Section does not, in and of itself, constitute a conflict of interest.

At the start of each IRB meeting the meeting Chair asks the members in attendance if they have any conflicts of interest with any item on the agenda. The minutes will record that no members have conflicts or the conflict that was disclosed and the actions that were taken.

The same prohibition on conflict of interest applies to any individual in the HRPP making decisions or determinations, including IRB Members acting as Expediters (see Section 10.2.2.1) and to IRB staff making exempt determinations (see Section 10.2.4.4).

3.10 IRB Support and Resources

(Revised 2/24/17)
The IRB Office provides administrative support for the IRB.

Boston Medical Center and Boston University provide the IRB office with appropriate office space, equipment and other support to perform its functions.

4 IRB Office Staff

4.1 Responsibilities of IRB Office Staff

(Revised 12/14/17)
The primary responsibility of the IRB Office staff is to support the IRB members and Chairs as they fulfill their review and other regulatory responsibilities.

The general responsibilities of the members of IRB Office staff include, but are not limited to:

- Receipt and tracking of submissions to the IRB; and
- Communicating with investigators and research staff to ask for any changes needed to make submissions complete and ready for IRB review; and
- Initial review of submissions to identify regulatory, legal or ethical issues; and
- Communicating with investigators and research staff to ask for any changes needed to make submitted consent forms complete (containing all required elements) and written in clear and simple language; and
- Initial determination as to whether a submission represents Not Human Subjects Research, qualifies as exempt or requires review by the expedited procedure or by the convened IRB; and
- Assignment of submissions for the convened IRB to primary and secondary reviewers; and
- If designated as an Expediter (see Section 10.2.2.1), performing expedited reviews of initial submissions, amendments, and progress reports; and
- If designated as an experienced staff person (see Sections 10.2.4.4, 10.2.5.4, 10.2.6, and 10.2.7), performing administrative review of exempt and Not Human Subjects Research submissions, internal study personnel changes, final reports, and changes to contact information in subject materials; and
- Preparation and distribution of agendas for IRB meetings; and
- Preparation of the minutes of IRB meetings; and
- Prompt notification of the Principal Investigators of actions taken related to their submissions; and
- Maintenance of complete, organized, and easily assessable IRB records, with particular attention to the integrity and security of the IRB records; and
- Forwarding communications from research subjects to the IRB Director; and
- Provision of education and assistance to investigators and research staff regarding IRB related issues; and
- Facilitation of communication among IRB Chairs/Vice Chairs, IRB members, investigators, and research staff.

4.2 IRB Operations

(Revised 9/28/16)
The IRB Director oversees the day to day operations of the Office of the IRB, and delegates responsibilities to IRB Office staff as appropriate in order to ensure completion of tasks. The IRB Director is accountable to the IRB Chairs for the timeliness and accuracy of administrative tasks completed for the IRB.

The IRB Director makes changes to internal processes as required to ensure that the Office is compliant with regulations and IRB policies and procedures.

4.3 IRB Administrators, Analysts, Coordinators, and Administrative Staff

(Revised 5/22/22)
The IRB Administrators, Analysts, Reliance Specialists, and Administrative staff process and review IRB submissions according to the procedures described in this document and internal processes developed by the Office of the IRB.

4.4 IRB Records

4.4.1 IRB Record Responsibilities

(Revised 8/11/19)
The Office of the IRB maintains IRB records in a confidential manner, in the IRB office, in a secure off-site records management facility, or in password protected, secure, electronic systems. It may take up to 10 business days for the IRB to obtain records stored in the offsite facility.

After March 15, 2004, all new studies have been submitted to the IRB using the electronic system. Studies that were approved prior to March 15, 2004 and were still ongoing at that time were converted from the paper format to the electronic format. All IRB documents submitted or created after implementation of the electronic system are stored within the electronic system. This system maintains the confidentiality of the records in accordance with Boston Medical Center and Boston University Medical Campus policies and is maintained by the Application Administrator and the Boston University IT department under the direct responsibility of the IRB Director.

The paper and electronic records may be inspected and copied/printed by FDA, OHRP, other federal or state government agencies, hospital accrediting agencies, or others, as appropriate. Original paper study files are not removed from the Office of the IRB without the permission of the IRB Director or designee.

At the discretion of the IRB Director and/or IRB Chairs, access to the electronic system is granted to other Boston Medical Center and Boston University offices including the Boston University Office of Research Compliance, Boston Medical Center Compliance Department, Boston University Office of Sponsored Programs, Boston Medical Center Office of Grants Administration, CRRO, Boston Medical Center Clinical Trial Office, Boston Medical Center/Boston University Faculty Review Committee on Research Financial Conflicts of Interest, Institutional Biosafety Committee, and Human Gene Therapy Committee. All those who are granted access are required to maintain the confidentiality of the documents and only use them for the purpose granted.

4.4.2 IRB Record Retention and Destruction

(Revised 11/29/16)
The Office of the IRB retains the study records listed in Section 4.4.3 for a minimum of 7 years after completion of the study.

The Office of the IRB contracts with a certified vendor to shred paper IRB documents and materials that are no longer needed.

4.4.3 IRB Record Scope

(Revised 6/20/18)
The Office of the IRB maintains IRB records, including but not limited to the following:

- IRB Membership Rosters (see Section 3.2) – IRB rosters are maintained by the IRB Director. Membership lists with the members' names, affiliations, and board roles are publicly available and posted on the IRB website; and
- Written Procedures and Guidelines (see Section 1.2) – Policies and Procedures are publicly available and posted on the OHRA website; and
- Electronic Submissions (see Section 7.2.2) – Materials reviewed by the IRB, including Initial Submissions, Amendments (including statements of any significant new findings provided to subjects), Continuing Reviews, Status Check-In Reports, Final Reports, Reportable Events and New Information, Emergency Use Reports, Notifications, Communications, and Correspondence, are stored in the password-protected electronic system; and
- Minutes of all IRB meetings (see Section 5.7) – IRB minutes are maintained electronically. Minutes are confidential documents and are not released to investigators, research staff, or sponsors or other departments unless approved by the IRB Director. Minutes are shared with regulatory agencies (i.e. OHRP, FDA) as required by the regulations; and
- Other documents related to IRB activities – Records concerning IRB reviews and meetings (including agendas, reviews by primary/secondary/expedited reviewers, educational materials, documentation of the responsibilities of institutions and IRBs in multi-site research, rationales for approving continuing review of research that otherwise would not require continuing review on or after January 21, 2019, rationales for determining that approved research appearing on an expedited review list is greater than minimal risk on or after January 21, 2019, and written rationales/approvals by the HRPP Director for exceptions to policies and procedures) are stored in the electronic system. These records do not include audiotapes of IRB proceedings that may have been used temporarily by the staff to help record the proceedings of the IRB meetings; and
- HRPP Advisory Committee meetings – Documentation of the proceedings of the HRPP Advisory Committee meetings and related communications are retained by the IRB Director or the Chair of the committee; and
- Other materials related to the operations of the Office of the IRB – Records related to the orientation and training of IRB office staff, IRB office staff meeting proceedings and agendas, communications with research subjects, and internal processes/SOPs are maintained by the IRB Director or designee; and
- Administrative forms used by the Office of the IRB – The IRB Director is responsible for the management of paper and electronic forms used by the IRB. New forms are approved by the IRB Director prior to use. Any person wishing to suggest a new form or revision of a current form must submit the suggestion in writing to the IRB Director along with a description of the rationale for the change. These requests are reviewed by the IRB Director, the HRPP Advisory Committee, the IRB Application Administrator, the IRB board members and/or IRB staff as appropriate.

5 IRB Meetings

5.1 Location of IRB Meetings

(Revised 5/22/22)
IRB board meetings are held in a suitable conference room on the Boston University Medical Campus, or are conducted using remote technology.

5.2 Scheduling of IRB Meetings

(Revised 10/23/22)
IRB boards meet as determined by a schedule set at the beginning of the academic year by the IRB Director. Scheduled meetings may be canceled or rescheduled for holidays, a lack of quorum, a lack of assigned submissions, or if the Boston University Chobanian & Avedisian School of Medicine is closed

due to weather. Panel meetings are cancelled or rescheduled by the action of the Chair of the panel in conjunction with the IRB Director.

5.3 Confidentiality of IRB Meeting Materials and Discussion

(Revised 6/30/16)
Orientation for board members (see Section 3.5.1) includes the confidentiality of IRB documents and discussions. Appointment letters will include language such as the following:

> "Your responsibilities include attending IRB meetings and participating in its activities to carry out the human subjects protection policies of the Boston Medical Center and Boston University Human Research Protection Program and other applicable institutional policies in compliance with all applicable laws. As an IRB member, you are expected to uphold the highest levels of ethics and integrity. You will have access to confidential information in submissions to the IRB, meeting discussions, communications concerning the matters that come before the IRB, and otherwise. Consistent with your institutional obligations concerning the protection of confidential and proprietary information, you are required to maintain the confidentiality of all non-public information entrusted to you. IRB members may not disclose any confidential information except as authorized by an appropriate institutional officer or as required by law. They may not use any confidential information except to carry out their obligations as IRB members. No information may be used by IRB members for their own benefit."

Non-affiliated members will sign an acknowledgement on the appointment letter and provide one signed copy to the IRB.

Visitors to IRB meetings will be given a written confidentiality reminder such as the following: "All non-public information accessed as a result of IRB meetings and all discussions that take place at IRB meetings are to remain confidential and may not be used for any individual's own benefit." Visitors who are not employees of Boston Medical Center or Boston University will be asked to sign a copy of the statement and provide it to the IRB.

5.4 Ex Officio IRB Members

(Revised 11/29/16)
Legal counsels from the Boston Medical Center Office of the General Counsel and the Boston University Office of the General Counsel regularly attend IRB meetings as non-voting members. They are also available to consult on issues regarding human subjects research. Ex officio members may participate in IRB deliberations and provide information and expertise as requested by the IRB. Ex officio members adhere to the same conflict of interest standards as voting members (see Section 3.9).

5.5 Visitors to IRB Meetings

(Revised 2/24/17)
Visitors are allowed to attend IRB meetings with the permission of the IRB Chair(s) or the IRB Director. Visitors may request permission to attend IRB meetings by contacting the IRB Director or one of the IRB office staff. Visitors are not allowed to remove any written materials that are distributed during the meeting from the meeting with the exception of educational materials. If during an IRB meeting the Chair moves the meeting to Executive Session then visitors are asked to leave the room until the Executive Session has ended.

If a study on the meeting agenda involves the visitor (as an investigator, research staff member, etc.) then visitors must make their interest in that study known to the Board Chair or IRB staff. The visitor may be allowed to stay in the meeting during the presentation of the study (at the discretion of the Board Chair), but the visitor must leave the room during the final discussion and vote on that study.

For situations where visitors may not be investigators or research staff, the IRB Chair retains the right to ask any visitors or non-voting IRB members to leave the room during the discussion and or vote of any studies or agenda items.

5.6 Quorum / Voting Procedures for IRB Meetings

(Revised 5/18/18)
After discussion of the study, the IRB members vote by a show of hands on their decision about the study, which can include approval, conditional approval, deferral, and disapproval (see Section 10.3.2). Votes (for, against, abstain), those recused, and the attendance are recorded in the minutes.

The IRB observes the following rules in its voting:

- Numerical requirements for quorum – A majority (>50%) of the voting board members must be present to achieve a quorum. The prisoner representative counts towards quorum when research involving prisoners is being reviewed; and
- Diversity requirements of quorum – At least one member whose concerns are non-scientific must be present. At least one physician member must be present when reviewing studies with FDA-regulated drugs, biological agents, or devices; and
- If either the numerical or diversity requirements for quorum are not met, no business can be transacted by the board; and
- Percent needed to approve or disapprove a motion – When a motion is made to approve, conditionally approve, defer, or disapprove a submission, in order for it to pass, the motion must be agreed upon by a majority (>50%) of the voting members present (including those who have abstained); and
- Full voting rights of all members:
    - Each member has one vote. If the member is unable to vote (absent or recused), then one appropriately designated alternate member may vote in place of the member.
    - Ex officio members are non-voting members; and
    - A board member may attend the meeting via teleconference and may vote during the meeting at the discretion of the Board Chair. This member must have received all pertinent information prior to the meeting and be able to participate actively and equally in all discussions; and
- Proxy votes – No proxy votes (written or telephone) are allowed; and
- Prohibition against conflict-of-interest voting – Members who have a conflict of interest may be present to answer questions about the study but then are required to leave the room and recuse themselves prior to the final discussion and voting. The presence of a conflict and the recusal are recorded in the minutes. Recused members are not counted towards quorum.

5.7 Minutes of IRB Meetings

(Revised 3/2/25)
Meeting agendas are prepared for each convened IRB meeting, and minutes are composed during the meeting.

Minutes contain, at a minimum

- The date, time, and location of the meeting; and
- A listing of voting board members, by board role, who are present (including alternate members replacing absent or recused members); voting board members who are absent; voting board members who have a conflict of interest; voting board members who are recused; ex officio board members who are present; non-voting board members and other IRB staff who are present; and any visitors or consultants who are present; and
- When a member joins or leaves the meeting, and any loss of quorum; and
- Educational materials distributed/discussed; and
- For each agenda item, a listing of separate actions and controverted issues and their resolution; and
- All votes on actions, including number of members voting for, against, those recusing themselves from voting (and/or from discussion) and those abstaining from voting on actions; and

- If a submission is approved, that the criteria for approval in Section 10.1.1.1 were met, as well as any additional criteria required by Federal Sponsors (see Sections 12.5, 12.6, 12.7, 12.8, 12.9, and 12.10); and
- The approval period for each approved initial submission or continuing review; and
- If changes to a submission are required or if a submission is disapproved, a reference to the basis for requiring the changes or for the disapproval in the electronic system; and
- Any determinations concerning exclusion of limited- and non-readers; and
- A reference to study-specific justifications in the electronic system for any waivers or alterations of the requirement for informed consent or for any waivers of informed consent documentation; and
- Any determinations regarding regulatory categories and references to study-specific justifications in the electronic system for research involving pregnant persons, fetuses, or neonates; prisoners; children; or decisionally-impaired persons; and
- Any determinations regarding the use of the short form consent process or Certificates of Confidentiality; and
- If revised consent forms are approved, whether and how, in addition to newly-recruited subjects, the revised forms must be used for any groups of already-consented subjects; and
- Any determinations related to IND Exemptions under 21 CFR 312.2(b), IDE exemptions under 21 CFR 812.2, or abbreviated IDEs for non-significant risk device studies under 21 CFR 812.2(b); and
- Any determinations related to management plans of Financial Conflicts of Interest (see Section 10.1.1.2.9); and
- The determinations and board actions pertaining to any targeted audits or Reportable Events and New Information reports considered by the board, including any urgent actions previously approved by the Chair or Vice Chair in response to unanticipated problems or deviations. Determinations include whether or not an event reported as an Unanticipated Problem meets the definition in Section 6.6.3.2 and whether or not the report provides evidence of serious or continuing noncompliance; and
- If research is suspended or terminated, the reasons for the suspension or termination; and
- The reasons for any changes required in materials approved by the Executive Board; and
- Any determinations required by HIPAA and its regulations and references to study-specific justifications in the electronic system, including determinations related to waivers of HIPAA authorization for research uses and disclosures of subjects' PHI as defined in the HIPAA regulations.

The Chair who acted as Chair during the meeting may independently review and approve the minutes. As part of this review, the Chair may request additions or corrections to the minutes prior to approval. The Chair has the discretion to determine that the minutes require review and approval during a subsequent convened IRB meeting. If minutes are reviewed during a subsequent convened IRB meeting, a general consent process may be used for approval of minutes, meaning that the Chair asks if there are any additions or corrections, and, if one is suggested, it is made and when no additions or corrections (or no further additions or corrections) are suggested, the minutes are considered approved.

The approved minutes are electronically signed by the Chair who acted as Chair during the meeting described in the approved minutes. Members have access through the electronic system to approved minutes for all meetings of their panel.

6 Investigators, Research Staff, and Sponsors

6.1 Qualifications to Perform Human Research

6.1.1 Investigator Identification of Study Staff

(Revised 11/18/19)

All individuals who will have contact with research subjects or their identifiable data in the performance of any exempt or non-exempt research-related activities, including enrollment, consenting, collection of

study data, interventions, long-term follow-up or data analysis, must be listed in initial submissions, and in amendments if added after the study has begun. This requirement applies to all studies, including those where Boston Medical Center or Boston University Medical Campus is relying on an external IRB (see Section 2.5.2.2). As part of the review process, the IRB staff verifies that all investigators and research staff listed on the submission have provided documentation of required training (human subjects protection training and GCP training as applicable, see Section 6.2.3). Study staff may not begin research activities until their inclusion has been given approval or an exempt determination.

6.1.2 Investigators Not Affiliated with Boston Medical Center or Boston University Medical Campus

6.1.2.1 External Investigators and Research Staff from Assured Institutions

(Revised 2/24/17)
Study investigators and research staff who are employees or agents as defined in Section 13 of an institution with an FWA other than Boston Medical Center or Boston University Medical Campus must be covered by their own institution's IRB or by the Boston Medical Center and Boston University Medical Campus IRB under an IRB Authorization Agreement.

Principal Investigators request the inclusion of a study investigator or research staff member from an assured institution by providing required information in the multi-site research section of the submission (see Section 7.2.2.16.6). The Principal Investigator is responsible for the supervision of all research staff, including external investigators and research staff.

6.1.2.2 External Investigators Not from Assured Institutions

(Revised 8/11/19)
If an investigator or research staff member is not acting as an employee or agent as defined in Section 13 of an institution with an FWA or of Boston Medical Center or Boston University Medical Campus, that investigator or research staff member must be covered by a Collaborating Institutional Investigator Agreement or an Individual Investigator Agreement with the Boston Medical Center and Boston University Medical Campus IRB.

Principal Investigators request the inclusion of investigators or research staff who will be covered by an Individual Investigator Agreement by providing required information in the multi-site research section of the submission (see Section 7.2.2.16.6). The Principal Investigator is responsible for directing and appropriately supervising the research activities of the collaborating external individual investigator. If the IRB agrees to accept review for any external investigator, the IRB will provide the Principal Investigator with a customizable template for a Collaborating Institutional Investigator Agreement or an Individual Investigator Agreement. The Principal Investigator is responsible for customizing the template agreement, obtaining the signature of the external investigator, and returning the signed agreement to the IRB.

The agreement is also signed by the appropriate IO or their designee.

The signature of the individual investigator confirms the following:

(1) The Investigator has reviewed: 1) *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (or other internationally recognized equivalent; see section B.1. of the Terms of the Federalwide Assurance (FWA) for International (Non-U.S.) Institutions); 2) the U.S. Department of Health and Human Services (HHS) regulations for the protection of human subjects at 45 CFR part 46 (or other procedural standards; see section B.3. of the Terms of the FWA for International (Non-U.S.) Institutions); 3) the FWAs and applicable Terms of the FWAs for the Boston Medical Center and the Boston University Medical Campus; and 4) the relevant institutional policies and procedures for the protection of human subjects.

(2) The Investigator understands and hereby accepts the responsibility to comply with the standards and requirements stipulated in the above documents and to protect the rights and welfare of human subjects involved in research conducted under this Agreement.
(3) The Investigator will comply with all other applicable federal, international, state, and local laws, regulations, and policies that may provide additional protection for human subjects participating in research conducted under this agreement.
(4) The Investigator will abide by all determinations of the Boston Medical Center and Boston University Medical Campus Institutional Review Board ("the IRB") and will accept the final authority and decisions of the IRB, including but not limited to directives to terminate participation in designated research activities.
(5) The Investigator will complete any educational training required by the IRB prior to initiating research covered under this Agreement.
(6) The Investigator will report promptly to the IRB any proposed changes in the research conducted under this Agreement. The investigator will not initiate changes in the research without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to subjects.
(7) The Investigator will report immediately to the IRB any unanticipated problems involving risks to subjects or others in research covered under this Agreement.
(8) The Investigator, when responsible for enrolling subjects, will obtain, document, and maintain records of informed consent for each such subject or each subject's legally authorized representative as required under HHS regulations at 45 CFR part 46 (or any other international or national procedural standards selected on the FWA for the institution referenced above) and stipulated by the IRB.
(9) The Investigator acknowledges and agrees to cooperate in the IRB's responsibility for initial and continuing review, record keeping, reporting, and certification for the research referenced above. The Investigator will provide all information requested by the IRB in a timely fashion.
(10) The Investigator will not enroll subjects in research under this Agreement prior to its review and approval by the IRB.
(11) Emergency medical care may be delivered without IRB review and approval to the extent permitted under applicable federal regulations and state law.
(12) This Agreement does not preclude the Investigator from taking part in research not covered by this Agreement.
(13) The Investigator acknowledges that they are primarily responsible for safeguarding the rights and welfare of each research subject, and that the subject's rights and welfare must take precedence over the goals and requirements of the research.

6.1.3 Students and Trainees as Investigators

6.1.3.1 General Requirements for Students and Trainees Conducting Research

(Revised 2/24/17)
Students and trainees conducting research as employees or agents of Boston Medical Center or Boston University Medical Campus must follow the same requirements for IRB review of research as other investigators and research staff if their activities constitute engagement in human subjects research. Trainees refer to interns, residents, fellows, and postdoctoral scholars.

6.1.3.2 Course-Related Projects

(Revised 8/11/19)
Course assignments and projects (collectively, "course-related projects") where the purpose is for students or trainees to learn the research process are usually not intended to and are not likely to lead to generalizable results. Therefore, the IRB does not routinely review these projects as they would not be considered to meet the definition of human subjects research. Course-related projects do NOT require IRB review if they:

- Do not involve a systematic investigation designed to develop or contribute to generalizable knowledge; and
- Do not involve physically or psychologically invasive, intrusive or stressful procedures;

- Do not involve research on special populations including subjects likely to be vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons;
- Do not involve accessing research repositories containing individually identifiable data or individually identifiable clinical databases/ medical records; and
- In the judgment of the instructor do NOT have the potential for placing the subjects at more than minimal risk.

Instructors are responsible for reviewing course-related projects to ensure they meet all of the criteria above. If an instructor determines that a research project does not meet any of criteria above, it must be submitted to the IRB for review.

6.1.3.3 Students and Trainees Working at Other Institutions

(Revised 2/24/17)
If a student or trainee involved in research activities at another institution is not acting as an employee or agent of the Boston Medical Center or Boston University (for example, for summer work), then neither Boston Medical Center nor Boston University is engaged in the research, so review by the Boston Medical Center and Boston University Medical Campus IRB is not required. Otherwise, such review is required. The Boston Medical Center and Boston University Medical Campus IRB may approve the research or enter into an IRB Authorization Agreement with the other institution (see Section 2.5).

Section 2.4 outlines criteria for assessing engagement in research. In the specific case of student and trainee research, Boston Medical Center or Boston University Medical Campus IS engaged in research if:

- Boston Medical Center or Boston University is receiving a direct award (funding) for the student or trainee research project; or
- The student or trainee is conducting research to fulfill a requirement of Boston Medical Center or Boston University; or
- The Supervising Principal Investigator is from Boston Medical Center or Boston University Medical Campus.

6.1.3.4 Student and Trainee Research

(Revised 12/22/25)
When a student or trainee undertakes research other than that described in Sections 6.1.3.2 and 6.1.3.3, the student or trainee must either create a separate IRB submission or have the Principal Investigator of an already-approved study submit an amendment, if the project of the student or trainee qualifies as an amendment to the approved research. Students or trainees who create a separate IRB submission must have a Supervising Principal Investigator who is eligible to be a Principal Investigator (see Section 6.2). The student or trainee may be listed as the Principal Investigator and the mentor as Supervising Principal Investigator or the mentor may be listed as the Principal Investigator with the student or trainee listed as a coinvestigator.

The Supervising Principal Investigator is responsible for assisting in designing the research and preparing the IRB submission (while the IRB can offer assistance, the IRB cannot take the place of the mentor for training and supervising the student or trainee).

The Supervising Principal Investigator has the same responsibilities for protecting the human subjects in the research as the Principal Investigator (see Section 6.6.1).

If the student or trainee Principal Investigator and the Supervising Principal Investigator are affiliated with different departments overseen by different IRBs (the Charles River Campus IRB and the Boston Medical Center and Boston University Medical Campus IRB), in most instances review by only one IRB will be required (see Section 2.5.1). The student or trainee should contact one of the IRBs, and the respective IRB Directors will consult to determine which IRB will serve as the IRB of record for the research based on where the majority of the research activities will take place and where the most risk will occur. The

student or trainee will then be asked to submit a full description of the study to the IRB that is serving as the IRB of record and to submit a request to cede review to the other IRB.

6.1.3.5 Students and Trainees Who Work on Other Principal Investigators' Research Projects

(Revised 2/24/17)
Students and trainees who work on another Principal Investigator's research project as investigators or research staff follow the same processes as other investigators and research staff for being listed on the original submission or added using the amendment process.

6.2 Requirements for Principal Investigators

6.2.1 Principal Investigator Qualifications

6.2.1.1 Requirements for All Principal Investigators

(Revised 2/24/17)
Principal Investigators must possess the appropriate background, training, and professional qualifications to conduct the research required for each study. Investigators and research staff listed on the submission must possess the appropriate license(s) and institutional privileges to perform the research activities assigned to them in the study. It is the responsibility of the Principal Investigator of the study to ensure that all research related activities in the study are assigned to individuals who have appropriate licenses, qualifications and privileges so that the rights and the welfare of subjects are protected.

6.2.1.2 Requirements for Principal Investigators on Investigator-Initiated Clinical Trials

(Revised 2/24/17)
For a study meeting the definition of a clinical trial (see Section 13) that is initiated by the Principal Investigator at Boston Medical Center or Boston University Medical Campus, as the first step in the submission process, the Principal Investigator is required to have a consultation with the CRRO (see Section 6.4.3) unless this requirement is waived by the IRB Director. This requirement is effective for initial submissions on or after May 1, 2017.

6.2.2 Principal Investigator Affiliations

(Revised 2/24/17)
To serve as the Principal Investigator on a Boston Medical Center or Boston University Medical Campus research study an investigator must be:

- A member of the faculty or staff of Boston Medical Center or Boston University; or
- A student or trainee with a Supervising Principal Investigator from Boston Medical Center or Boston University.

Exceptions to this policy may only be made by the IRB Director. Investigators who wish to serve as the Principal Investigator must comply with any additional requirements for Principal Investigators from Boston Medical Center or Boston University.

Investigators with a Conflict of Interest may serve as the Principal Investigator if the Conflict of Interest is managed under a management plan approved by the IRB and by Boston Medical Center or Boston University.

6.2.3 Investigator and Research Staff Training Requirements

6.2.3.1 Initial Training Requirements

(Revised 2/24/17)

Human Subjects Protection training is required for all individuals involved in human subject research studies (exempt and non-exempt) who have contact with subjects or their identifiable data. The Collaborative Institutional Training Initiative (CITI) online training is used to fulfill this requirement. The CITI Human Subjects Protection course, either the Biomedical or the Social-Behavioral course, must be completed for initial training. CITI Human Subjects Protection modules completed through other institutions may be transferred through the CITI site.

Good Clinical Practice (GCP) training is required for all individuals involved in clinical trials (as defined in Section 13), in any of the following categories:

- Biomedical clinical trials submitted for initial approval on or after November 1, 2016, with any source of funding or support; and
- Social-behavioral clinical trials that are submitted for initial approval on or after May 1, 2017, with any source of funding or support; and
- Clinical trials supported by the National Institutes of Health (NIH), with any submission date (effective March 1, 2017).

The GCP training requirement can be satisfied by:

- Completing the CITI GCP course; or
- Completing the Social and Behavioral Best Practices eLearning Course; or
- Attending a GCP course for professional staff or for Principal Investigators offered by the CRRO (see Section 6.4.3); or
- Completing other GCP training, if documentation is provided to the IRB regarding the topics covered and the individual's completion of the course and the IRB Director considers the training to be acceptable. A list of additional GCP training courses that have been accepted is available on the OHRA website.

It is the responsibility of the Principal Investigator to ensure that all study personnel comply with the requirements for Human Subjects Protection and GCP training. Failure to ensure that all study personnel have required training is a major deviation that must be reported as described in Section 6.6.5.2 and may be considered continuing noncompliance according to the review process described in Section 11.4.3 after two notices have been sent to the Principal Investigator concerning training deficiencies.

Sponsor-investigator training provided by the CRRO (see Section 6.4.3) is required for Principal Investigators who are also taking on the role of Sponsor for an FDA-regulated drug or device study. A sponsor holds the IND or IDE (see Sections 12.1 and 12.2). This training must be completed prior to IRB approval of research that is submitted on or after November 1, 2016. The training will be adjusted as appropriate if the Principal Investigator has previously received sponsor-investigator training.

6.2.3.2 Renewal of Training

(Revised 1/30/17)
Renewal of Human Subjects Protection training is required every three years for those involved in human subjects research and must be accomplished by taking the CITI refresher course for Human Subjects Protection.

Renewal of GCP training is required every three years and may be accomplished by taking the CITI refresher course for GCP or by completing a GCP initial or refresher course offered by the CRRO or other organization.

6.2.4 Medical Expertise Requirements

(Revised 2/24/17)
The IRB may require that the Principal Investigator arrange for a physician with appropriate expertise and admitting privileges at an appropriate healthcare facility to be substantively involved with the research project, particularly if the research study or procedures are greater than minimal risk. The determination

as to the qualifications necessary for the research staff on each study are left up to the IRB board or Expediter that reviews the study.

6.2.5 Disqualification of a Proposed Principal Investigator

(Revised 6/29/17)
The IRB may determine that a proposed Principal Investigator may not serve as the Principal Investigator on a proposed study. This determination may be made because of the individual's conflict of interest; previous serious or continuing noncompliance (see Section 11.4.2); lack of licensure, medical staff membership, or sufficient qualifications to adequately oversee a specific research project; or other reasons deemed appropriate by the Board. In such cases the Board notifies the individual in writing as to the reasons why they may not serve as the Principal Investigator for the submission.

6.2.6 Principal Investigator of Record

(Revised 2/24/17)
The designation of the Principal Investigator of record must be consistent across research documents, including the IRB submission, General Clinical Research Center application, and informed consent form. The grant application for potential funding sources may list another principal investigator; however, the Principal Investigator of record on Boston Medical Center and Boston University Medical Campus research documents should be listed as a co-investigator on the grant application.

6.2.7 Principal Investigators in International Research

(Revised 2/24/17)
International research projects conducted through Boston Medical Center or Boston University Medical Campus must have a Principal Investigator at Boston Medical Center or Boston University Medical Campus, who is responsible for communications with the IRB.

6.3 Communication between the IRB and Principal Investigators

6.3.1 Responsibilities for Accuracy of Communications with the IRB

(Revised 2/24/17)
All formal communications are sent to the Principal Investigator via the electronic system. The Supervising Principal Investigator will receive all of the same communications as the student/trainee Principal Investigator. The Principal Investigator may request that other investigators and research staff also receive these communications. However, the Principal Investigator is ultimately responsible for all communication with the IRB (via the Office of the IRB). While the Principal Investigator may delegate these responsibilities to other study investigators or research staff, it is still the Principal Investigator's responsibility to verify the accuracy of all correspondence. All communications via the electronic system are password protected and Principal Investigator responsibilities include using their individual username and password as an electronic signature (see Section 6.6.1). The electronic system allows other study investigators and research staff to develop and revise initial submissions, responses, amendments, and progress reports. However, these documents require the electronic "signature" of the Principal Investigator before they can be submitted to the IRB via the electronic system (see Section 7.3.1).

6.3.2 Principal Investigator Communication with the IRB

(Revised 2/24/17)
Principal Investigators are required to maintain current contact information, including address, telephone number, fax number (as appropriate), and email address in their profile in the electronic system. Principal Investigators may opt to have emails from the electronic system sent to another email address but it is the Principal Investigator's responsibility to ensure that these emails are appropriately redirected to the new email address via the Boston University active directory. Questions or concerns related to email addresses are managed by the IRB Application Administrator. Failure to received redirected emails does not change the Principal Investigator's responsibility regarding communication with the IRB. Principal

Investigators are responsible for maintaining adequate records of communications with the IRB. Any communications through the electronic system are considered to be adequately recorded.

6.4 Training and Educational Opportunities for Investigators and Research Staff

6.4.1 Resources for Investigators and Research Staff

(Revised 2/24/17)
The CITI and eLearning programs available for investigators and research staff to meet training requirements are described in Section 6.2.3. The training available from the CRRO is described in Section 6.4.3. Ongoing education in human subjects research is also available via the monthly online Clinical Research Times newsletter published by the Office of Human Research Affairs. Boston University offers a number of courses in human research which are available to Boston Medical Center and Boston University faculty and staff.

6.4.2 Investigator and Research Staff Questions and Concerns

(Revised 2/24/17)
IRB staff and the IRB Director are available to assist investigators and research staff with questions and concerns regarding their IRB submissions. One or more IRB staff members function in the role of IRB Educators, who are available to answer general research related questions, assist with regulatory interpretation or to answer specific questions regarding IRB policies or the electronic system, and provide orientation to new investigators and research staff about IRB submissions.

6.4.3 CRRO Training and Assistance

(Revised 3/21/17)
The CRRO provides a range of services, resources, and guidance to support researchers at Boston Medical Center and Boston University Medical Campus in planning, submitting, conducting, and analyzing their research. The CRRO website maintains an up-to-date list of training and assistance resources, as well as slides and video or audio files of many past presentations.

Clinical research education programs offered by the CRRO include:

- A monthly seminar devoted to clinical research conduct, design, management, and practice issues; and
- Initial and renewal courses on conducting clinical trials that satisfy the requirement for GCP training (see Section 6.2.3.1). For initial training separate courses are offered for professional staff and for Principal Investigators; and
- Special training presentations and workshops with in-depth discussion of topics covered in the GCP courses; and
- Required training for sponsor-investigators (see Section 6.2.3.1). This one-on-one training will be scheduled at the convenience of the sponsor-investigator. The sponsor-investigator may choose to have research staff in attendance at this training.

Consultation services provided by the CRRO include:

- Assistance with the IRB submission process, including planning the study submission, determining the review path, reviewing the submission material, assisting with IRB stipulations after the study has been reviewed by the IRB, assisting with consent forms and the consent process, and developing Data Safety and Monitoring Plans. Assistance with study design, statistical issues, and forms development is also available through referral to experts within the Clinical and Translational Science Institute; and
- Assistance in study implementation, including how to follow regulations, policies, and guidelines to help ensure effective processes related to documentation, consenting, eligibility determination, and adverse event monitoring and reporting; and

- Guidance for sponsor-investigators concerning their responsibilities and obligations in conduct of IND/IDE research, including assistance with preparation and submission of IND/IDE applications to the FDA and management of IND/IDEs.

6.5 Investigator and Research Staff Conflict of Interest

6.5.1 Disclosure of Conflicts of Interest

(Revised 8/12/23)
All individuals responsible for the design, conduct, or reporting of the proposed research must disclose their Significant Financial Interests related to the research (as defined in the research conflicts of interest policies for Boston Medical Center and Boston University, see Section 13). Boston Medical Center investigators must make disclosures through the Boston Medical Center Compliance Department's web based system, COI Smart. Boston University investigators must complete and submit a Financial Interest Disclosure Form as described here http://www.bu.edu/orc/programs-committees/coi/. The Principal Investigator confirms in the IRB submission that all required forms have been filed (see Section 7.2.2.5).

It is the responsibility of the Principal Investigator to ensure that all study personnel comply with the requirements for disclosure of conflicts of interest. Failure to ensure that all study personnel have disclosed their Significant Financial Interests related to the research is a major deviation that must be reported as described in Section 6.6.5.2 and may be considered continuing noncompliance according to the review process described in Section 11.4.3 after two notices have been sent to the Principal Investigator concerning disclosure deficiencies.

6.5.2 Evaluation of Disclosed Conflicts of Interest

(Revised 8/24/20)
For studies where an individual who is responsible for the design, conduct, or reporting of the proposed research has a Significant Financial Interest related to the research, the Boston Medical Center/Boston University Faculty Review Committee on Research Financial Conflicts of Interest will determine if the individual has a Financial Conflict of Interest. If so, this committee establishes a management plan to minimize, manage or eliminate the Financial Conflict of Interest that is accepted by the conflicted individual. Notification regarding the accepted management plan is sent to the IRB Director who informs the IRB. The IRB may then approve the management plan or require alterations to the management plan to impose additional or more restrictive requirements to manage the Conflict of Interest as described in Section 10.1.1.2.9.

6.6 Principal Investigator Responsibilities when Conducting Research

6.6.1 General Responsibilities of the Principal Investigator

(Revised 12/18/22)
The Principal Investigator is required to:

1. Understand what research activities are overseen by the HRPP and consult with HRPP staff if in doubt about whether submission to the IRB is required; and
2. Personally log into the electronic system using their individual username and password as an electronic signature; and
3. Provide information to the HRPP that is complete and accurate to the best of their knowledge; and
4. Design studies to protect individuals conducting the study, to adhere to ethical principles and standards appropriate to their discipline, to safeguard the rights and welfare of all human subjects, to minimize risks, to have adequate provisions to monitor the data for safety, to draw subjects from a population selected to distribute the risks and benefits fairly, to employ additional safeguards necessary to protect vulnerable populations, to safeguard research data, and to meet all applicable HIPAA requirements; and

5. Determine that adequate resources will be available to carry out the study, including facilities, access to an appropriate population, medical and psychological resources for subjects, and sufficient time and staff to conduct the research; and
6. Ensure that prior to beginning work on the study, the Principal Investigator and all members of the research team meet all applicable Boston Medical Center and Boston University requirements for the disclosure and management of conflicts of interest; have all required training, qualifications, credentials, and licenses; and are trained on and appropriately delegated responsibility for study procedures; and
7. Not initiate any human subjects research activities until an IRB final outcome letter has been received and all required institutional approvals have been obtained; and
8. Be responsible for execution and management of the study, including oversight of all study personnel and any sub-awardees/subcontractors under their direction; and
9. Comply with all applicable terms, conditions, assurances and certifications referenced in the application, award (grant or contract), and protocol; and with all applicable state, federal, and local laws, rules, regulations, policies, and guidelines, as well as institutional policies (including those pertaining to IRB requirements, patient confidentiality, HIPAA, debarment, finances and record retention) related to this study; and
10. Follow the IRB-approved research plan by recruiting subjects in a fair and equitable manner; by adhering to the approved inclusion and exclusion criteria and maintaining appropriate source documentation that demonstrates adherence; by employing the approved process for obtaining and documenting informed consent; by meeting all applicable HIPAA and other data security requirements; by maintaining the privacy of subjects and protecting the confidentiality of data; by responding appropriately to and documenting the response to subjects, prospective subjects, and family members who request information or have concerns or complaints; and by providing aggregate and/or individual study results to subjects if promised; and
11. Maintain all required records, including documentation (regulatory documents, source documents, and study data) that demonstrates compliance with the IRB-approved study application and/or protocol, and cooperate with any request for auditing by the HRPP, sponsor, or government agency; and
12. Comply with all requirements for identifying and reporting Unanticipated Problems, Adverse Events, deviations, and safety monitors' reports, and any other new or significant information that might impact a subject's safety or willingness to continue in the study; and
13. Ensure that IRB approval is obtained prior to making any change to the approved study plan, consent form, or study personnel unless the change is immediately necessary for the safety of subjects; that IRB approval for continuation is obtained prior to the study expiration date; that a status check-in is provided before the due date for studies without expiration dates; and that a Final Report is submitted to close the study at the appropriate time.

6.6.2 Continuing Reviews and Status Check-Ins

6.6.2.1 Continuing Review for Studies with Expiration Dates

6.6.2.1.1 Conduct of Continuing Review

(Revised 1/17/18)
Continuing Review of approved studies with expiration dates is conducted in accordance with Section 10.1.2. See Section 10.4.1 for a discussion of how review intervals and expiration dates are determined.

6.6.2.1.2 Principal Investigator Responsibilities for Continuing Review

(Revised 1/17/18)
The Principal Investigator is responsible for submitting a Progress Report to the IRB via the electronic system for review and approval prior to expiration of the study. The expiration date is indicated in the IRB outcome letter and notifications from the electronic system. The electronic system sends notifications as courtesy reminders to Principal Investigators informing them of the upcoming expiration of the study at 7 weeks, 6 weeks, 5 weeks, 2 weeks, and one day prior to study expiration. When a study expires, a notification of the study expiration is sent via the electronic system.

6.6.2.1.3 Progress Report Requirements

(Revised 8/30/16)
Continuing review of approved research is substantive and meaningful as described in Section 10.1.2. The required information in the Progress Report is described in Section 7.4.3.1.

6.6.2.1.4 Timely Submission of Progress Reports

(Revised 2/24/17)
It is the responsibility of the Principal Investigator to ensure that a study does not expire. The Principal Investigator is required to submit the Progress Report no less than 4 weeks prior to the expiration date to allow the IRB time to process the submission. Failure of the Principal Investigator to receive renewal notices does not excuse the Principal Investigator from the responsibility to submit Progress Reports on time.

6.6.2.1.5 Expiration of IRB Approval

6.6.2.1.5.1 Requirement to Cease Study Activities

(Revised 8/30/16)
The continuation of research after expiration of IRB approval is not permitted, unless it is in the best interests of already enrolled subjects to continue participating in the research (see Section 6.6.2.1.5.2). If the IRB has not received a Progress Report and approved continuation of a research study by the study's current expiration date, all study related activities must cease, including recruitment, enrollment, study interventions, long-term follow-up and analysis of identifiable information.

6.6.2.1.5.2 Interventions after Study Expiration for the Best Interests of Subjects

(Revised 9/16/26)
The exception to ceasing study activities after approval has expired is if it is in the best interest of individual subjects to continue participating in the research interventions or interactions. Continuing participation of already enrolled subjects in a research project during the period when IRB approval has expired may be appropriate, for example, when the research interventions hold out the prospect of direct benefit to the subjects or when withholding those interventions pose increased risk to the subjects.

The determination regarding whether it is in the best interest of individual subjects to continue in the research because there would be increased risks to the subjects if the study was stopped may be made initially by the Principal Investigator, possibly in consultation with the subjects' treating physician. The Principal Investigator must submit as soon as possible, and no later than 7 calendar days after study expiration, a request for confirmation that the IRB agrees with this determination. The review by the IRB may be made by the Chair, by another IRB member or group of IRB members designated by the Chair, or at a convened IRB meeting. If the IRB determines that it is not in the best interest for each individual subject or group of subjects to continue on the study during the lapse in approval, all human subjects research activities must stop, including intervening or interacting with subjects and obtaining or analyzing their identifiable private information until the IRB has renewed approval for the study. If the IRB determines that it is in the best interests for some or all subjects already enrolled to continue, enrollment of new subjects cannot occur, and this is not and should not be seen as the IRB granting of an extension of approval for a study. The Principal Investigator must submit a Progress Report if not already submitted as well as a report of a major deviation including a Corrective and Preventative Action plan to prevent future lapses in study approval (see Section 6.6.5.2).

6.6.2.1.5.3 Reporting of a Lapse in Approval

(Revised 2/24/17)
When continuing review of a research study does not occur prior to the end of the approval period specified by the IRB, approval of the study automatically expires. Such expiration (lapse in IRB approval)

is not reported to OHRP as a suspension. The expiration of approval is reported by the IRB to the appropriate grants office.

6.6.2.1.5.4 Re-Instating a Lapsed Study

(Revised 1/17/18)
Once approval for a study has lapsed, the Principal Investigator must submit a Progress Report and receive full IRB approval in order to re-instate the study. If any human subjects research activities (including analysis of identifiable data) took place after the expiration date of approval, this constitutes a major deviation and must be reported, along with a Corrective and Preventative Action plan, according to Section 6.6.5.2. If not, the lapse constitutes a minor deviation and is reported in the Progress Report. Research activities cannot be re-instated until the Progress Report has been reviewed and fully approved. A pattern of failure by a Principal Investigator to submit timely Progress Reports or Status Check-In Reports may be determined by the IRB to constitute continuing noncompliance (see Section 11.4.2).

6.6.2.2 Status Check-In Reports for Studies without Expiration Dates

(Revised 8/11/19)
The Principal Investigator is responsible for submitting a Status Check-In Report to the IRB via the electronic system for studies approved without expiration dates, for studies given an exempt determination on or after January 21, 2019, and for studies submitted for ceding to an external IRB on or after September 1, 2019. See Section 10.4.1.4 for a discussion of studies that may be approved without expiration dates. The status check-in due date is indicated in the IRB outcome letter and in notifications from the electronic system. The electronic system sends notifications as courtesy reminders to Principal Investigators informing them of the upcoming status check-in due date prior to the due date. If the Status Check-In Report has not been submitted as required, Principal Investigators are notified on and after the due date that they are in noncompliance with IRB requirements. Failure to submit a required Status Check-In Report after at least one notification that noncompliance has occurred may be considered continuing noncompliance (see Section 11.4.2) and thus may constitute a major deviation requiring submission of a Reportable Events and New Information form (see Section 6.6.5.2). The required information in the Status Check-In Report is described in Section 7.4.3.2.

6.6.3 Reporting of Information Relevant to Subjects' Rights, Safety, and Well-Being

6.6.3.1 Reporting of Adverse Events to Sponsors and Federal Agencies

(Revised 2/24/17)
Adverse Events, including Serious Adverse Events, as defined in Section 13, must be reported to the study sponsor and/or the appropriate federal agency as required by the regulations and the data safety monitoring plan approved by the IRB.

If the study involves an FDA regulated test article with the IND or IDE held by the sponsor, Principal Investigators must notify the study sponsor. Principal Investigators should check the study protocol and procedure manual for details on what needs to be reported, how soon, and to whom.

If the study involves an FDA regulated test article with the IND or IDE held by the investigator, the Principal Investigator must notify the FDA directly. The Principal Investigator may also need to notify the entity that holds the original IND for the investigational product being tested.

For NIH-funded research, Principal Investigators are instructed to consult their Project Officers (different Institutes have different reporting requirements).

6.6.3.2 Reporting of Unanticipated Problems to the IRB and IBC

(Revised 9/16/26)

An event, experience, or outcome meets the definition of an Unanticipated Problem if it meets **all three** of the following criteria (see Section 13):

- It is unexpected; and
- It is related or possibly related to participation in the research; and
- It suggests that the research places subjects or others at a greater risk of harm than was previously known

Unanticipated Problems must be reported to the IRB via the electronic IRB system (see Section 7.4.5). For multi-site research where another IRB is the IRB of record, the Principal Investigator must follow the reporting requirements of the IRB of record, and in addition, must report Unanticipated Problem determinations made by the IRB of record related to events that occur at the Boston Medical Center or Boston University Medical Campus site ("internal" Unanticipated Problems) to the Boston Medical Center and Boston University Medical Campus IRB (see Section 2.5.4). For multi-site research where the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record, the local Principal Investigator is responsible for reporting via the electronic IRB system (see Section 7.4.5) Unanticipated Problems occurring at both local and external sites, obtaining the information from external sites as necessary.

The report of the Unanticipated Problem must be made as soon as possible but no later than 7 calendar days after the investigator or research staff learns of the incident.

The submission must describe the Unanticipated Problem and either specify what changes to the research are required or explain why no changes are necessary. A separate amendment request must also be submitted for the required changes (see Section 7.4.1.2), but this requirement should not delay the submission of the Unanticipated Problem report.

For studies involving gene transfer, any Unanticipated Problem determinations must also be submitted to the Institutional Biosafety Committee (IBC) within 7 calendar days of the investigator or research staff learning of the incident.

6.6.3.3 Reporting of Safety Monitors' Reports with Required Changes or Recommended Changes Involving Subject Safety to the IRB

(Revised 9/16/26)

Principal Investigators must notify the IRB through the electronic system when they receive a report from a safety monitoring body that contains required changes in the protocol, consent form, or other aspect of the research, or recommended changes that involve subject safety (see Section 7.4.5). Reporting is required in addition to the submission of the amendment request (see Section 7.4.1.2). This report must be made as soon as possible but no later than 7 calendar days after the investigator or research staff member receives the report from the safety monitoring body.

6.6.3.4 Reporting of Adverse Events that are Not Unanticipated Problems

(Revised 2/24/17)

The Principal Investigator must submit a summary report of all Adverse Events (including Serious Adverse Events) that are NOT Unanticipated Problems to the IRB via the electronic IRB system at the time of the continuing review and at study closure. A formal report by a data safety monitor satisfies the requirement for a summary report. The summary must include an analysis of whether the pattern of events, in total, suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm), based on their nature or frequency of occurrence.

6.6.3.5 Reporting Requirements After a Study has Closed

(Revised 2/24/17)

Any information received by the investigator or research staff after the study has been closed that relates to the rights, safety, or well-being of study subjects must be reported to the IRB. If subjects must be

notified of the new information, a copy of the proposed notification must be included in the submission to the IRB. The notification must be approved by the IRB before any communication with subjects.

6.6.4 Amendments and Modifications to Research

6.6.4.1 Requirement to Follow the Approved Research Plan

(Revised 2/19/18)
Principal Investigators are required to conduct a non-exempt study precisely according to the IRB approved submission. No modifications, additions or other changes can be made to the approved research plan (including minor changes to study personnel, eligibility criteria, research interventions, recruitment methods, consenting procedures, etc.) without prior IRB approval unless necessary to eliminate immediate harm to subjects. Changes made, without prior IRB approval, to eliminate apparent immediate hazards must be reported in the same way as a major deviation as described in Section 6.6.5.2.

6.6.4.2 Requesting Approval for Changes in Approved Studies

(Revised 2/24/17)
Principal Investigators request IRB approval for proposed changes in study personnel, study application information, consent forms, or study documents via the electronic system as described in Section 7.4.1. The changes may not be implemented until IRB approval has been obtained.

6.6.4.3 Requests for Protocol Exceptions

(Revised 2/24/17)
A protocol exception is a request for a planned, single departure from the IRB approved protocol. The Protocol Exception submission form should be used in the electronic system as described in Section 7.4.2 to assist the IRB in identifying the submission as possibly needing urgent attention. The Principal Investigator is responsible for any required notification to the sponsor or funding agency. The exception may not be implemented until IRB approval has been obtained.

6.6.5 Deviations

6.6.5.1 Classification of Deviations

(Revised 6/30/16)
Deviations represent incidents, circumstances or processes that occur during the research that are not part of or are inconsistent with the approved IRB study plan, HRPP policies and procedures, or Federal regulations.

A protocol exception does not constitute a deviation if it was submitted according to Section 6.6.4.3 and approved prior to implementation.

Deviations are divided into two categories: Major and Minor.

6.6.5.2 Major Deviations

(Revised 9/16/26)
Major deviations are deviations that may (1) harm the participant's rights, safety or well-being, (2) significantly damage the overall reliability of the study data, or (3) represent noncompliance with IRB requirements that may be serious or continuing. Major deviations must be reported to the IRB as soon as possible but no later than 7 calendar days of the investigator or research staff becoming aware of the event.

The criteria for defining major deviations include any of the following:

- The deviation has harmed, or posed a significant or substantive risk of harm to, the research participants; or
- The deviation resulted in a change to any participant's clinical or emotional condition or status; or
- The deviation has the potential to significantly damage the overall completeness, accuracy and/or reliability of the data collected for the study; or
- The deviation was enrollment of participants who did not meet the eligibility requirements; or
- The deviation was failure to obtain informed consent prior to any study-specific tests/procedures; or
- The deviation was continuing to perform human subjects research activities after the expiration date of study approval; or
- The deviation was enrolling more than the IRB-approved number of subjects in research that is greater than minimal risk; or
- The deviation was nonadherence to an IRB-approved or sponsor-required Corrective and Preventative Action plan; or
- The deviation was noncompliance with 21 CFR Part 11 requirements for electronic records and electronic signatures when compliance with 21 CFR Part 11 is the responsibility of the Principal Investigator, as described in Section 12.4.7; or
- The deviation was noncompliance with the registering, updating, or posting requirements for clinical trials on ClinicalTrials.gov (see Section 6.6.9); or
- The deviation has resulted in a privacy incident, meaning unauthorized access, use, or disclosure of research participant information; or
- The deviation is evidence of willful or knowing misconduct on the part of investigators or research staff; or
- The deviation involves noncompliance with federal, state or local law or regulations or HRPP policies that may be serious or continuing.

Changes made to eliminate an apparent immediate hazard to subjects must be reported in the same way as major deviations.

Major deviations are reported using the electronic system as described in Section 7.4.5 and are evaluated as described in Section 11.4.

A separate submission is required for any amendment (see Section 7.4.1), Progress Report (see Section 7.4.3.1), or Status Check-In Report (see Section 7.4.3.2) that is required to correct a major deviation or eliminate an apparent immediate hazard to subjects, including changing study procedures, modifying consent forms, adding study personnel, increasing the number of subjects, providing a Progress or Final Report for an expired study, and completing a late Status Check-In Report.

6.6.5.3 Minor Deviations

(Revised 1/17/18)

Minor deviations are any unapproved changes in the research study design and/or procedures that do not have a major impact on the participant's rights, safety or well-being, or on the reliability of the overall study data. Minor deviations must be reported in aggregate to the IRB at the time of continuing review or of status check-in.

Examples of minor deviations include, but are not limited to:

- Routine lab work missed at a scheduled visit or done outside the protocol-defined window for a participant without new clinical concerns and a history of previously normal lab values. The lab will be done at the next opportunity and is expected to remain within normal limits; or
- Research staff miss giving a study-required self-administered quality of life questionnaire to a participant; or
- A subject fails to comply with study procedures but the noncompliance does not affect the subject's rights, safety, or well-being; or

- A Progress Report is not submitted before the expiration date of approval but no human subject research activities (including no analysis of identifiable data) have taken place during the lapse in approval; or
- More subjects were enrolled or more records were reviewed than the IRB-approved number in research that is no greater than minimal risk. An amendment to increase the number of subjects should be submitted if enrollment is continuing.

6.6.6 Study Closure

(Revised 3/11/24)
The Principal Investigator is required to notify the IRB when their study is eligible to be closed. The IRB considers the closure to be appropriate when all human research activities have ceased or when remaining activities are limited to analysis of data that have been de-identified (e.g., by destroying the key) or storage of identifiable information without analysis. No further analysis using the identifiable data may occur until an amendment to reopen the closed study for such analysis or a new submission has been approved.

Final reports must be submitted when a non-exempt or ceded study is closed, including when a study is terminated by the Principal Investigator or the sponsor prior to the anticipated end of the protocol.

Non-exempt or ceded research is closed by submitting a Final/Closure Report Form using the electronic system (see Section 7.4.4). The Principal Investigator is permitted to close exempt research within the electronic system without the need for submission of a Final/Closure Report Form by changing the study status to closed.

Letting a study lapse by failing to submit a Final Report for a non-exempt or ceded study or failing to change the status of an exempt study to closed before the expiration date or status check-in date does not fulfill the requirement to close a study. The IRB will check new submissions to determine whether the Principal Investigator is responsible for any lapsed studies as Principal Investigator or Supervising Principal Investigator (formerly known as Faculty Sponsor). If so, the Principal Investigator will be informed that the new study will not be considered by the IRB until the lapsed study has been closed. This policy is effective for studies lapsing after May 31, 2016.

6.6.7 Maintaining Research Records

6.6.7.1 Length of Record Retention

(Revised 11/29/16)
It is the Principal Investigator's responsibility to maintain all study records (including source documentation) according to institutional, sponsor, and federal requirements. Study records must be retained for a minimum of 7 years after the end of the study according to Boston Medical Center policy #39.04.455 and Boston University policy #FA-002.

A longer retention period may be required by the sponsor of the study or by other circumstances such as a pending investigation. Sponsor-investigators with INDs must assure that the retention period also complies with requirements based on the date of marketing application approval or notification to the FDA; specifically, to assure that study records are retained for at least 2 years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and FDA is notified (see 21 CFR 312.62(c)). Sponsor-investigators with IDEs must assure that the retention period also complies with requirements based on the date of communications to the FDA; specifically, to assure that study records are retained for at least 2 years after the later of the following two dates: the date on which the investigation is terminated or completed, or the date that the records are no longer required for purposes of supporting a premarket approval application or a notice of completion of a product development protocol (see 21 CFR 812.140(d)).

It is the responsibility of the Principal Investigator to be aware of and comply with all requirements for record retention.

6.6.7.2 Inspection of Research Records

(Revised 7/25/16)
The HRPP retains the right to inspect any and all research records related to the study at any time during the active stage of the study, during follow-up and after the study has been closed. The HRPP may conduct audits of research at any time (see Section 11.3). The Principal Investigator is required to allow an audit and to make all research materials available to the auditors (see Section 6.6.1) and failure to do so would be considered noncompliance (see Section 11.4)

6.6.8 Principal Investigators Who Leave Boston Medical Center or Boston University Medical Campus

(Revised 2/11/24)
If a Principal Investigator leaves Boston Medical Center or Boston University Medical Campus and/or is no longer a member of the Boston Medical Center or Boston University Medical Campus faculty or staff then human research activities cannot continue at Boston Medical Center or Boston University Medical Campus unless a new qualified individual accepts responsibility as the Principal Investigator. If the responsibility is not transferred to a qualified individual as Principal Investigator, then the study must be closed.

Closure according to the requirements in Section 6.6.6 is appropriate when the research has been completed and there are no plans to analyze any identifiable data or samples, either by the Principal Investigator at their new institution or by any person remaining at Boston Medical Center or Boston University Medical Campus. Principal Investigators are required to close all active studies prior to leaving the institution rather than simply leaving and letting the study expire or miss its check-in due date. The Principal Investigator retains the responsibility for maintaining research records described in Section 6.6.7, and if the study is closed before the required record retention time period, the Principal Investigator must designate an individual remaining at Boston Medical Center or Boston University Medical Campus who will have access to study records as needed for audits or other purposes.

Closure is also appropriate when the departing Principal Investigator wishes to move the study in its entirety to a new institution. Such a transfer cannot take place until the IRB of new institution has issued its approval, including plans for use of identifiable research data and PHI. If the Principal Investigator leaves before such approval is obtained, a new Principal Investigator at Boston Medical Center or Boston University Medical Campus may be temporarily designated until IRB approval or exemption determination has been obtained at the new institution and the study is closed at Boston Medical Center or Boston University Medical Campus. All additional institutional requirements must be met (see http://www.bu.edu/researchsupport/tools-services/faculty-departure-checklist/), including those for any transfer of data and specimens.

When human subjects research activities will continue at Boston Medical Center or Boston University Medical Campus, the existing Principal Investigator must request through the electronic system the change in Principal Investigator. The new individual must be eligible to serve as a Principal Investigator (see Section 6.2) and must have the necessary licenses and privileges. The existing Principal Investigator must submit an Internal Study Personnel Changes form (see Section 7.4.1.1) and, if any interactions with subjects are continuing, must also submit a revised consent form listing the new Principal Investigator and any other applicable revised documents seen by subjects. Requests to change the Principal Investigator or Supervising Principal Investigator for non-exempt research are reviewed through the expedited procedure in Section 10.2.2.4.2.1. Requests to change the Principal Investigator or Supervising Principal Investigator for Not Human Subjects Research/Not Engaged research, exempt research, or ceded research are administratively reviewed by an experienced member of the IRB staff, as described in Section 10.2.7.1. The new Principal Investigator is notified of the IRB approval of the change in Principal Investigator via the electronic system.

If the departing Principal Investigator wishes to transfer any research data or specimens to their new institution, whether or not the study is closed at Boston Medical Center or Boston University Medical Campus, the same standards apply as for any release of data or specimens outside Boston Medical Center or Boston University. Release of specimens cannot occur until after agreements for material and data transfer have been signed. In addition, releases of data or specimens must either be consistent with the original consent form and HIPAA authorization or new consent and authorization must be obtained. Confidentiality protections must be adequate at the new institution and the approval of the IRB from the new institution must be obtained according to its policies for review of research involving analysis of data or specimens.

If the departing Principal Investigator has an active registration record on ClinicalTrials.gov, the Principal Investigator must contact the PRS Administrator to discuss plans for either maintaining the record with Boston Medical Center or Boston University Medical Campus or transferring the record to their new institution. The PRS Administrator will consult with the HRPP Director about plans for keeping or transferring ClinicalTrials.gov records for departing Principal Investigators.

6.6.9 Registering, Updating, and Posting Requirements for Clinical Trials

(Revised 2/24/26)
All studies meeting the definition of a clinical trial according to the International Committee of Medical Journal Editors (see Section 13) must be registered on ClinicalTrials.gov before final IRB approval is issued.

For all studies meeting the definition of a clinical trial, IRB approval will be issued only after the NCT number (assigned at registration on ClinicalTrials.gov) is communicated to the IRB as documentation that the trial has been registered. The responsible party must comply with all applicable updating and posting requirements (see http://www.bumc.bu.edu/ohra/clinicaltrials-gov/).

For clinical trials that involve an IND or IDE held by the Principal Investigator at Boston Medical Center or Boston University Medical Campus, the Principal Investigator is the responsible party, regardless of how the clinical trial is funded.

For clinical trials that are initiated by an external sponsor and do not involve an IND or IDE held by the Principal Investigator at Boston Medical Center or Boston University Medical Campus, the responsible party is the sponsor of the clinical study, as defined in 42 CFR 11.10(a).

For all other clinical trials that are initiated by the Principal Investigator at Boston Medical Center or Boston University Medical Campus, the responsible party is the home institution of the Principal Investigator (Boston Medical Center or Boston University).

Boston Medical Center and Boston University Medical Campus will register a study on ClinicalTrials.gov if the Principal Investigator is the sponsor of the study, and/or if Boston Medical Center or Boston University Medical Campus is the prime awardee of the external funding, or if Boston Medical Center or Boston University Medical Campus is determined to be the main site in a multi-site study.

If results are required to be posted, the initial submission of results must occur no later than 10 months after the actual primary completion date, to allow time for results review by ClinicalTrials.gov.

For clinical trials supported by a Federal department or agency that are approved on or after January 21, 2019, if the Principal Investigator at Boston Medical Center or Boston University Medical Campus is the responsible party, the Principal Investigator must ensure that one blank IRB-approved informed consent form used to enroll subjects is posted on ClinicalTrials.gov after the clinical trial is closed to recruitment, and no later than 60 days after the last study visit by any subject, as required by the protocol.

If Boston Medical Center or Boston University Medical Campus registers a study on ClinicalTrals.gov and the Principal Investigator departs the institution while the record is still active, the Principal Investigator must contact the PRS Administrator prior to departure to discuss plans for the record, as described in Section 6.6.8.

6.7 Sponsor Expectations

(Revised 2/24/17)
Contracts and funding agreements should contain provisions to contribute to the protection of human subjects in sponsored research. The Boston Medical Center Clinical Trial Office and the Boston University Office of Sponsored Programs will negotiate contracts and funding agreements to ensure that the following requirements are addressed:

- The provisions for medical care for research subjects with a research-related injury, if applicable; and
- The responsibility to communicate findings that could affect the safety of the subjects or influence the conduct of the study. The communication should be to the Principal Investigator, who will then report to the IRB as appropriate (see Section 6.6.3). The findings that should be communicated are:
    - Findings that could affect the safety of the subjects or the conduct of the study found through site monitoring visits or remote monitoring, if such monitoring is conducted; and
    - Data and safety monitoring plans and reports, if the study includes data and safety monitoring; and
    - Study results that could directly affect subject safety, even after the study has closed; and
- The provisions regarding publication of results in compliance with policies of Boston Medical Center and Boston University for the open and timely dissemination of research outcomes.

7 Research Proposal Submission

7.1 Method of Submission to the IRB

(Revised 8/11/19)
All research studies must be submitted to the IRB using the electronic system found on the IRB website.

To gain access to the electronic system, individuals must be registered in the Boston University or Boston Medical Center Active Directory.

Each person in the electronic system receives an individual secure, unique username and password. Principal Investigator responsibilities include using their individual username and password as an electronic signature (see Section 6.6.1). Boston Medical Center and Boston University IT policies specifically prohibit the sharing of passwords or the use of another's password.

7.2 Initial Submission

7.2.1 Submission Requirements

(Revised 2/24/17)
To request review of a research project, the Principal Investigator must submit information as described in Section 7.2.2 using the electronic system. Guidelines for use of the electronic system are available on the IRB website. Communications between investigators/research staff and the IRB concerning requests for changes, clarifications, or additional materials for the submission may take place entirely through the electronic system or may include phone conversations and/or in-person meetings, with any formal requests being subsequently documented in the electronic system.

7.2.2 Requirements for Submitted Materials

7.2.2.1 Requirements Based on Review Path

(Revised 10/27/21)
Principal Investigators are asked to indicate if they believe that their submission qualifies for a determination of Not Human Subjects Research/Not Engaged, for relying on another IRB (cede review), or for a determination of exempt. Principal Investigators are also asked to indicate whether the submission is for a chart review, for a report of an emergency use of an investigational drug or device that has already occurred, or for a study involving an individual patient IND or Humanitarian Use Device. Submission requirements for such review paths are:

- Not Human Subjects Research/Not Engaged – Sections 7.2.2.2, 7.2.2.3, and 7.2.2.17
- Cede review – Sections 7.2.2.2, 7.2.2.3, 7.2.2.4, 7.2.2.5, 7.2.2.6, 7.2.2.8, 7.2.2.16.4, and 7.2.2.18
- Exempt – Sections 7.2.2.2, 7.2.2.3, 7.2.2.4, 7.2.2.5, 7.2.2.7, 7.2.2.10, 7.2.2.11, 7.2.2.16.2, 7.2.2.16.6, and 7.2.2.19
- Emergency use – Sections 7.2.2.2 and 7.2.2.21
- Individual patient IND – Sections 7.2.2.2, 7.2.2.4, 7.2.2.5, 7.2.2.8.1, and 7.2.2.22
- Humanitarian Use Device – Sections 7.2.2.2, 7.2.2.4, 7.2.2.5, 7.2.2.8.2, and 7.2.2.23

For chart review submissions, additional required information must be provided to determine whether or not the study is eligible for exempt category (4) (see Sections 10.2.4.2.1.1 and 10.2.4.2.1.2) or equivalent protections exempt category (9) (see Sections 10.2.4.2.2.1 and 10.2.4.2.2.2). The chart review submission will then follow the requirements for exempt submissions if eligible and for non-exempt submissions otherwise.

7.2.2.2 Required Basic Information

(Revised 7/20/26)
The basic submission information must include:

- Study title; and
- Study lay summary (except for Not Human Subjects Research and cede review); and
- Associated department(s); and
- Key Study Personnel:
  - Principal Investigator (required); and
  - Supervising Principal Investigator (required if the Principal Investigator is a student, resident, or fellow); and
  - Any additional study investigators or research staff (those having contact with subjects and/or their identifiable information); and
  - Any administrative personnel not engaged in research but needing access to the electronic system; and
  - The Department Chair or Section Chief authorized to sign off on the submission (required); and
- Funding source; and
- Grant application, if applicable, prior to January 21, 2019; and
- Whether the study is initiated by the Principal Investigator; and
- Whether the study is a clinical trial; and
- If the study is both initiated by the Principal Investigator and is a clinical trial, the date upon which consultation with the CRRO took place or upon which the IRB Director waived this requirement. This requirement is effective for such initial submissions on or after May 1, 2017; and
- If the study involves in-person subject interaction in Boston Medical Center clinical space or requires study staff to be on-site in Boston Medical Center clinical space to conduct study activities, the name and title of the individual who authorized use of Boston Medical Center clinic space for these research activities, as well as the date this approval was obtained; or, the name and title of the individual who will be asked for approval for use of Boston Medical Center clinical space for these research activities and indication that this approval is pending; and
  - Home Institution of the Principal Investigator (Boston Medical Center/Boston University Medical Campus, BMC Brighton, or BMC South); and
- Features requiring special routing to the following entities for review (applicability may vary by home institution) (see Section 7.3.3):

- Perinatal Research if the study involves human research subjects from Labor & Delivery, the post-partum inpatient floors, the neonatal intensive care unit (NICU), or the Well Baby Nursery of Boston Medical Center or, if the research solely involves the study of pregnant or inpatient postpartum patients at Boston Medical Center (including chart review research); and
- Cancer or Oncology Research if the study is a trial that recruits patients with cancer for treatment of disease or symptoms; pertains to cancer prevention or detection; studies cancer survivors; or collects data on patients with cancer, whether prospectively or retrospectively; and
- Department of Pediatrics Clinical Areas if the study is being conducted in the Ambulatory Pediatrics clinical area, Inpatient Pediatric Unit or Pediatric Intensive Care Unit, or Pediatric Emergency Room; and
- Division of Psychiatry if the study involves subjects who are being recruited from the psychiatry or behavioral health services at Boston Medical Center or mental health clinical programs affiliated with Boston Medical Center; will utilize data of patients who are or have been getting psychiatric treatment at Boston Medical Center or its affiliates; or will require the assistance of staff or faculty of the Division of Psychiatry at Boston Medical Center or its affiliates; and
- BU CTSI General Clinical Research Unit or BMC Clinical Research Unit if the study takes place in the applicable Clinical Research Unit or uses applicable Clinical Research Unit resources; and
- Nursing Department if the study requires inpatient or outpatient nursing care, other than by nurses who work for the investigator or the BU CTSI General Clinical Research Unit or the BMC Clinical Research Unit, to help conduct the research or if the Principal Investigator is a nurse at Boston Medical Center. For studies that meet these criteria, a description of the nursing roles and responsibilities that are required for conducting the study and the plan for initial and continuing training of inpatient and/or outpatient nursing staff must be included; and
- Laser Safety if the study deals with lasers, light emitting diodes, photon induced photo acoustic streaming, or low level light therapy; and
- Radiology if the study involves research-only radiological imaging studies; and
- Goldman School of Dental Medicine if any students or residents from the Goldman School of Dental Medicine will be involved in the design or conduct of the study; and
- BMC Clinical Trial Office if the study involves, without limitation, the provision of any of the following Boston Medical Center clinical services or use of Boston Medical Center infrastructure (note that retrospective chart reviews are not considered to involve such services or infrastructure):
  - Investigational Pharmacy Service; or
  - Investigational Device (IDE) implants; or
  - Infusion services; or
  - Radiology (e.g. MRI, CT/PET/MUGA Scans); or
  - Pathology (e.g. histology slides); or
  - Lab Medicine (processing or providing analysis of blood/tissue samples); or
  - Cardiology (e.g. EKGs); or
  - Ophthalmology (e.g. retinal exams); or
  - Performing physical exams in Boston Medical Center clinical space; or
  - Drawing blood in Boston Medical Center clinical space; and
- Pathology if the study involves procuring and/or processing samples, i.e. tissue or slides, through Pathology at Boston Medical Center; and
- Laboratory Medicine if the study includes activities that require the involvement of Laboratory Medicine services at Boston Medical Center such as specimen procurement, lab testing, phlebotomy, or point of care testing.

Additional features that require special routing to the following individuals or entities (see Section 7.3.3) are:

- The Human Gene Therapy Committee if the study involves gene transfer or gene therapy (see Section 7.2.2.16.2); and
- The Institutional Biosafety Committee if the study involves collecting biological samples for research purposes (see Section 7.2.2.16.3); and

- Investigational Pharmacy Services if the study involves administering drugs or biological agents (see Section 7.2.2.8.1); and
- The Massachusetts Controlled Substance Registration Research Licensure Administrator if the study involves administering a drug under an IND that is stored in Massachusetts (see Section 7.2.2.8.1); and
- Boston Medical Center Research & Sponsored Programs if the study involves investigators outside of Boston Medical Center (including investigators whose home institution is Boston University Medical Campus) accessing or using data or biological samples derived from BMC patients; and
- The Boston Medical Center Research Technology Program if the study:
    - Involves technology that is used for research purposes to further the care of Boston Medical Center patients, or;
    - Involves technology that is used to gather data from Boston Medical Center patients for research purposes, or;
    - Involves software that is integrating with existing software hosted by Boston Medical Center for research purposes; or
    - Is administered through Boston Medical Center or uses patient data generated at Boston Medical Center and uses, develops, or tests artificial intelligence (AI), machine learning (ML), or large language models (LLMs) at any point in the research, and;
- Biomedical Engineering if the study involves the use of an investigational electrical (AC or battery) device (see Section 7.2.2.8.2); and
- Radiation Safety if the study involves radiation exposure for subjects specifically for research purposes, either from x-rays, Radiation therapy machines, dexascans or from isotopes (see Section 7.2.2.16.5); and
- The Boston Medical Center Chief Medical Officer if the study targets Boston Medical Center employees, residents or fellows for recruitment (see Section 7.2.2.10 and Section 9.6); and
- The Associate Dean, Student Affairs, of the Boston University Chobanian & Avedisian School of Medicine if the study targets Boston University Medical students for recruitment and the research involves studying student affairs, such as aspects of student life, the medical student experience, student wellness, and/or student attitudes (see Section 7.2.2.10); and
- The Associate Dean, Office of Medical Education, of the Boston University Chobanian & Avedisian School of Medicine if the study targets Boston University Medical students for recruitment and the research involves studying medical education, such as research on education instructional strategies, and/or research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods (see Section 7.2.2.10); and
- The Dean of Graduate Medical Sciences at the Boston University Chobanian & Avedisian School of Medicine if the study targets Boston University Graduate Medical Sciences students for recruitment (see Section 7.2.2.10); and
- The Associate Dean for Research and Faculty Advancement of the Boston University School of Public Health if the study targets Boston University public health students for recruitment (see Section 7.2.2.10); and
- The Associate Director of the Office of Research in the Boston University Henry M. Goldman School of Dental Medicine if the study targets Goldman School of Dental Medicine students for recruitment (see Section 7.2.2.10).

7.2.2.3 HIPAA Compliance Information

(Revised 2/24/17)
The submission information about HIPAA compliance must include whether any PHI will be accessed without signed authorization from the individual whose information is needed.

The submission information when PHI is accessed without authorization must include:
- The purpose of accessing PHI without authorization, most commonly for medical record review or to identify and contact subjects for recruitment; and
- The selection criteria for the records to be accessed; and
- The date range for the records to be accessed; and

- The data fields that are needed from the medical record; and
- Whether research staff and/or the Clinical Data Warehouse staff will be accessing the records; and
- Whether any HIPAA identifiers are included in the data accessed; and
- Why the research cannot be conducted without access to PHI without authorization; and
- Why it is not practical to obtain authorization from the participants; and
- What the plan is to protect any identifiable information from use and disclosure by unauthorized parties; and
- When and how identifiers linked to the data will be destroyed (identifiers should be destroyed at the earliest opportunity as consistent with the design of the research).

In addition, when PHI is accessed without authorization, the Principal Investigator must confirm that:

- The PHI will not be re-used or disclosed to any other person or entity, except as required by law, for the authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted by the Privacy Regulation (45 CFR 164.512); and
- The requested information constitutes the minimum necessary data to accomplish the goals of the research.

7.2.2.4 Investigator Training Information

(Revised 12/22/23)

The Principal Investigator must confirm in the submission that:

- All individuals acting as agents of Boston Medical Center or Boston University Medical Campus who will have contact with subjects or their identifiable data are listed in the submission (including those who will obtain informed consent, analyze identifiable data, perform study interventions, recruit subjects, etc.); and
- All listed individuals have completed their profile in the electronic system or have been asked to do so; and
- All listed individuals are up to date with their training requirements (see Section 6.2.3); and
- If the research targets BMC patients for enrollment, or uses BMC patient data, or utilizes BMC facilities and/or services, all listed individuals are up to date with the required institutional Standard Operating Procedures (SOP) training.

7.2.2.5 Conflict of Interest Information

(Revised 2/19/18)

The Principal Investigator must confirm in the submission that all those responsible for the design, conduct, or reporting of the proposed research have complied with the Conflict of Interest requirements in Section 6.5 and must indicate whether any Significant Financial Interests related to the research (as defined in Section 13) have been disclosed.

7.2.2.6 Recruitment Information

7.2.2.6.1 Recruitment Procedures Information

(Revised 1/17/18)

The submission information about recruitment procedures must include a detailed description of how the research population will be identified, and how potential subjects will be contacted and provided information about the study. The recruitment plan should draw subjects from a population selected to distribute the risks and benefits of the research in an equitable manner. The recruitment procedures should employ adequate confidentiality protections for potentially damaging information; for example, if potential subjects are being recruited because they have a health condition such as HIV/AIDS or a psychiatric disorder, the recruitment process should ensure that this will not be revealed to anyone other than the potential subject.

7.2.2.6.2 Incentives among Investigators, Sponsors, and Referring Providers

(Revised 9/15/20)
The Principal Investigator must confirm their compliance with the following requirements:

- Investigators and research staff may not receive direct or indirect remuneration that constitutes an inducement for recruiting or enrolling subjects; and
- Investigators and research staff may not accept any bonus payments based on the rate or timing of subject recruitment or enrollment; and
- Investigators and research staff performing research involving medical services must comply with federal and state anti-kickback laws and applicable anti-kickback policies of Boston Medical Center and Boston University; and
- Investigators and research staff may not offer payment or financial incentives to any healthcare providers for referring patients to research studies (finder's fees).

Note that these requirements do not apply to receiving compensation for research activities as long as the compensation is commensurate with the effort needed to do the research.

7.2.2.6.3 Recruitment Material Requirements

(Revised 6/29/17)
Principal Investigators must submit any advertising or publicity information including recruitment letters, flyers, posters, public service announcements, newspaper, radio and television advertisements, and Internet content seeking study subjects for research. If recruitment materials are not ready at the time of initial submission, they may be submitted subsequent to study approval as an amendment. No recruitment materials may be used until IRB approval is obtained. Principal Investigators must comply with the requirements of the institutions where the recruitment materials are distributed or posted.

Recruitment materials should include the following information, as applicable:

- A clear statement that this is research and not treatment; and
- A statement about the purpose of the research; and
- The eligibility criteria (summary form); and
- Time commitments and other commitments for subjects; and
- The location of the research; and
- The name and telephone number or email address of a contact person or office; and
- The institution's logo (when appropriate); and
- Any reimbursement or payments provided to subjects, with the following restrictions:
  - The amount may be specified by stating, for example, "up to $xxx"; and
  - The amount may NOT be emphasized by using large, bold, underlined, italicized font or by putting this information first in the ad before the study purpose, procedures, and time commitment.

Recruitment materials must not include:

- Any exculpatory language (statements waiving or appearing to waive any legal rights or providing a release from liability for negligence); or
- Any claims, either explicit or implicit, about a drug, biologic agent, or device under investigation that are inconsistent with FDA labeling; or
- Any terms, such as "new treatment," "new medication," or "new drug," without explaining that a test article is investigational.

7.2.2.6.4 Recruitment using Community Health Centers

(Revised 2/24/17)
The submission information for studies that will recruit using one or more Community Health Centers must include details about the Community Health Centers that are involved and the activities that will take place at the Community Health Centers. Documentation of approval from each Community Health Center must be provided to the IRB before any research activities may begin at the Community Health Center.

7.2.2.6.5 Screening Procedures Information

(Revised 9/16/26)
The submission information about screening procedures must include whether the study includes any screening procedures that involve:

- For studies submitted prior to December 1, 2019, collecting and retaining, without obtaining consent, any potentially damaging information or PHI that can be linked to the potential subjects; or
- Any clinical screening procedures (i.e., a procedure involving a physical intervention, specimen collection, or more than minimal physical risk, such as a blood draw, imaging study, or fasting) performed solely for the purpose of determining eligibility for the research; or
- Collecting information by direct contact with potential subjects prior to obtaining informed consent from them using the primary consent form for the study.

If such screening will occur, the submission information must include:

- A description of the procedures that will be used for screening to determine subject eligibility; and
- What eligibility data will be collected, how these data will be stored, who will have access to these data, and when these data will be destroyed; and
- For screening failures, how and what data will be retained, if any, along with when these data will be destroyed, including whether identifiers are being retained from those who screen out and whether contact information is being retained for future research; and
- The process by which consent for the screening will be obtained. A consent form meeting the criteria of Section 8.2 is required if the screening involves any clinical procedures, unless the study qualifies for a waiver or alteration of the consent process under Section 7.2.2.12.3. For all other screening involving direct contact with potential subjects, a consent process meeting the criteria of Section 8.1.3.4 is required; and
- Copies of any screening scripts, surveys, or forms and other screening related documents.

7.2.2.7 Collection and Protection of Data

7.2.2.7.1 Privacy Protections Information

(Revised 8/11/19)
Privacy refers to individuals' control over who has access to them or to information about them. The Principal Investigator either must confirm that subject privacy is protected by obtaining the minimum information necessary to conduct the study and by carrying out interventions and interactions with subjects and potential subjects in private settings, or must describe other appropriate measures to protect privacy.

7.2.2.7.2 Confidentiality Protections Information

7.2.2.7.2.1 Confidentiality of the Data

(Revised 12/20/20)
Confidentiality refers to the protection of identifiable private information.

The submission information about confidentiality for submissions before July 1, 2019 must include either a statement that data will be recorded as anonymous, meaning that there will be no way to link data to individual subjects, even temporarily, and that subjects' identities cannot be reasonably ascertained via deductive disclosure OR a description of how data will be secured. Options for securing the data include:

- Using a code to identify subjects in all study data. The code is a unique study ID which will be linked to subject identities by a master-code or key. Access to the master-code or key will be limited to the researchers by using secure electronic and/or hardcopy storage; or
- If subject names or other identifiers (such as medical record number) are used to identify subjects in any study data, access to the identifiable data will be limited to the researchers by using secure electronic and/or hardcopy storage.

The submission information about confidentiality for submissions on or after July 1, 2019 must include one of the following choices:

- Study data/results, documents, Case Report Forms, and other documents/files will be identified with a unique study ID #. The study ID # will be linked to a master-code list that contains all study ID #s and direct subject identifiers. The master-code list will be maintained separately from study files and access limited to the researchers, with one of the two following options:
  - Study data/results, Case Report Forms, and other documents/files for subjects who have been assigned a study ID # may also contain subject identifiers that by themselves or when combined with other identifiers, could result in identifying a subject; or
  - Study data, documents, Case Report Forms, and other documents/files for subjects who have been assigned a study ID # will NOT contain any subject identifiers that by themselves or when combined with others identifiers, could result in identifying a subject; or
- All study data, documents, Case Report Forms, and other documents/files will be recorded as anonymous. There is NO master-code. There will be no reasonable way to link study data and documents to individual subjects, even temporarily AND subject identities cannot be reasonable ascertained via deductive disclosure, with a description of how the data will be recorded anonymously; or
- There is an alternate plan for how subject will be identified in study data, documents, Case Report Forms, and other documents/files. The alternate plan must be described,

The submission information about confidentiality must also include a description of how data will be secured and a confirmation that the electronic storage of any Protected Health Information or Personal Information (as defined in Section 13) will comply with applicable policies for secure storage under Boston Medical Center policies or Boston University policies.

The submission information about confidentiality for submissions on or after July 1, 2019 must include whether data will be shared with a third party vendor or software application or program; if so, whether they will use an option already-approved by Boston Medical Center or Boston University, or whether they will request to use an unapproved option. If they will use an approved option, they must provide the name of the third party. For studies submitted on or after March 1, 2020, if they request to use an unapproved option, the information must include the date upon which the study team contacted the appropriate Boston Medical Center or Boston University data security office to allow for the review of the privacy and security practices of the third party.

7.2.2.7.2.2 Release of Identifiable Data

(Revised 12/20/20)

The submission information about release of identifiable information must include:

- Whether identifiable data are being transmitted to an individual or entity outside of Boston Medical Center and Boston University Medical Campus, and if so, a description of what information will be released, the circumstances under which the information will be released, to whom the information will be released, and how confidentiality will be maintained during data transmission, such as by use of encrypted email, encrypted flash drives, or a sponsor-provided data capture system.

When information is required to be released outside of the research context (such as child abuse, certain communicable diseases, or suicide risk), the consent form must reflect this information (see Section 8.2.3).

7.2.2.7.2.3 Communication of Pertinent and Incidental Findings to Subjects and/or their Physicians

(Revised 2/24/17)

Both pertinent and incidental findings are findings that are discovered in the course of conducting research and that have potential health or reproductive importance to the individual subject. Pertinent findings are findings related to the aims of the study (e.g., disease risk, abnormal lab findings), and incidental findings are finding unrelated to the aims of the study (e.g., imaging abnormalities, genetic

results). The submission information about communication of pertinent and incidental findings must include whether the research (including screening) involves any procedure or test done for research purposes only that may reveal pertinent and/or incidental findings that are of potential health or reproductive importance to the individual subjects, and if so, either a description of the plan for what will be disclosed, to whom, and how, or the reasons why no findings will be communicated.

The study should have a communication plan if the research is expected to yield pertinent and/or incidental findings that are clinically significant (analytically valid and of known clinical significance and utility). If applicable, the communication plan should address procedures in the case that there will be a treating relationship between an investigator and one or more subjects. If the study is approved with a statement that no pertinent or incidental findings will be communicated, any future plans for communication must be submitted as an amendment and must be approved by the IRB prior to any communication with subjects and/or their physicians.

The plan for communicating pertinent and/or incidental findings should include:

- What criteria will be used to determine which pertinent and/or incidental findings will be communicated:
  - The reliability of the tests/images, such as being done in a CLIA-certified lab; and
  - Whether the meaning and significance of the findings are known; and
  - Whether the findings reveal a significant risk of a serious health condition; and
  - Whether there is an accepted treatment for the health condition revealed by the tests/images that can change the clinical course of the condition; and
  - The risks both of knowing and not knowing the findings, including risks to family members from genetic testing results; and
  - What risks and costs are associated with required follow-up testing and counseling; and
  - Any other relevant considerations, including the response to unanticipated factors that may arise in the future; and
- What information will be provided during the consent process about the plans for communicating pertinent and/or incidental findings; and
- Whether the subjects will be given the option of refusing communication of some or all types of pertinent and/or incidental findings to themselves, their family members, and/or their physician; and
- To whom and by whom the pertinent and/or incidental findings will be communicated, when, and how.

7.2.2.7.2.4 Destruction of Identifiers

(Revised 2/24/17)
The submission information about destruction of identifiers must include when and how any non-anonymous data will be de-identified, such as by destruction of the master-code list.

7.2.2.7.2.5 Certificate of Confidentiality (CoC)

(Revised 8/11/19)
A Certificate of Confidentiality (CoC) provides protection against disclosure of identifiable research information (see Section 9.7.2). For studies funded by NIH or the Centers for Disease Control (CDC), the submission information about CoCs must include an acknowledgement that a CoC is automatically granted. For studies not funded by NIH or CDC, the submission information about CoCs must include whether the study involves obtaining identifiable information that requires the additional protection of a CoC; if so, the CoC must be obtained before collection of identifiable information may begin.

7.2.2.8 Use of Drugs, Biological Agents, or Devices

7.2.2.8.1 Drug and Biological Agents Information

(Revised 3/2/25)

The submission information about any drug or biological agent, including placebos (collectively referred to as “drug”), administered as part of the study (that is, the dose, timing, and route of administration are defined in the study plan) must include:

- The trade, generic, and/or investigational name; and
- Whether the drug is FDA approved; and
- Whether the study involves the new use of an approved drug (new indication or new dosage form); and
- Whether an IND is required (the drug is new or a new use of an approved drug with a significant change in risks); and
- If an IND is required:
  - The IND number; and
  - Who holds the IND; and
  - Details about the IND; and
  - Whether the IND is being used in another research study; and
- If an IND is not required, an explanation of why not, either
    - that the use is not investigational, and the Principal Investigator confirms that:
        - The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug/biological agent; and
        - If the drug/biological agent that is undergoing investigation is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product; or
    - that the use complies with the exemption requirements in 21 CFR 312(b) (see Section 12.1.2); and
- The name of the manufacturer or source of the investigational drug; and
- Whether the drug is supplied at no cost; and
- Dosing details:
  - Dose range; and
  - Frequency; and
  - Route of administration; and
- Whether the investigational pharmacy will be dispensing; and
- If the source is not a FDA licensed facility, details regarding the purity, quality, stability and sterility of the investigational drug; and
- Who will be preparing the investigational drug for administration and details about how it will be prepared; and
- The indication(s) under investigation; and
- Drug Schedule (i.e. I, II, III, IV, V, or VI); and
- Drug storage restrictions (including temperature, etc.); and
- Administration instructions; and
- Possible untoward effects, their symptoms and treatment; and
- Potential or actual antidotes for excessive or adverse drug effects; and
- Known contraindications and interactions; and
- The investigators who are authorized to prescribe the drug; and
- Where the drug will be stored

For each drug listed, the investigator’s brochure or the drug package insert must be attached to the submission.

If the study proposes to use an electronic system managed by Boston Medical Center or Boston University for documentation of electronic records and electronic signatures, the submission information must include the name of the electronic system.

For submissions where the Principal Investigator holds the IND, a description must be provided of any intellectual property interest in the drug or biologic agent of any investigator on the study, such as the right to royalties under a Patent Policy.

7.2.2.8.2 Device Information

(Revised 10/23/22)
The submission information for a study that uses a device other than a device used for routine measurements or monitoring (such as an EKG machine) must include:

- A description of any intellectual property interest in the device of any investigator on the study, such as the right to royalties under a Patent Policy; and
- The categorization of the device as:
  - Experimental use of an approved device. This may require an Investigational Device Exemption (IDE); or
  - Humanitarian Use Device; or
  - Experimental device other than in vitro diagnostic device (Requires an IDE or abbreviated IDE determination); or
  - In vitro diagnostic device; or
  - A device used for its FDA approved or cleared indication in one of the exemption categories specified in Section 12.2.3; and
- For experimental use of an approved device, a humanitarian use device, or an experimental device other than an in vitro diagnostic device, whether the use of the device in this study constitutes use of a non-significant risk device; and
- For uses of devices characterized as non-significant risk devices:
  - An explanation of why the use is non-significant risk; and
  - A confirmation by the Principal Investigator that the study will comply with the requirements in Section 12.2.4.2; and
- For experimental use of an approved device, a humanitarian use device, or an experimental device other than an in vitro diagnostic device, a description of the process to control investigational devices so that they are used only in approved research protocols and under the direction of designated study team members; and
- For in vitro diagnostic devices, a confirmation by the Principal Investigator that the device and testing will comply with the following:
  - The device will be labeled according to the following requirements:
    - If the device is in the laboratory research phase of development, and not represented as an effective in vitro diagnostic product, all labeling bears the statement, prominently placed: “For Research Use Only. Not for use in diagnostic procedures.”; and
    - If the device is being shipped or delivered for product testing prior to full commercial marketing (for example, for use on specimens derived from humans to compare the usefulness of the product with other products or procedures which are in current use or recognized as useful), all labeling bears the statement, prominently placed: “For Investigational Use Only. The performance characteristics of this product have not been established.”; and
  - The testing:
    - Is noninvasive; and
    - Does not require an invasive sampling procedure that presents significant risk; and
    - Does not by design or intention introduce energy into a subject; and
    - Is not used as a diagnostic procedure without confirmation of the diagnosis by another, medically established diagnostic product or procedure.

For each device used in the study, the submission information must include:

- The name of the device; and
- Whether the device is FDA approved; and
- Whether the study involves the new use of an already approved device; and
- Whether an Investigational Device Exemption (IDE) is required (new device or new use of an already approved device); and
- If an IDE is required:
  - The IDE number; and
  - Who holds the IDE; and

  - Details about the IDE; and
- The manufacturer or supplier of the device; and
- Where the device will be stored; and
- Whether the device will be supplied at no cost; and
- Whether the device is a Humanitarian Use Device, and if so, the Humanitarian Device Exemption (HDE) number; and
- Whether the study involves the use of an investigational electrical (AC or battery) device.

If the study proposes to use an electronic system managed by Boston Medical Center or Boston University for documentation of electronic records and electronic signatures, the submission information must include the name of the electronic system.

For each device listed, if there is an investigator's device brochure or Instructions for Use, it should be attached to the submission.

7.2.2.9 Risks and Benefits Information Requirements

(Revised 10/27/17)
The submission information about risks must include:

- a listing of all potential risks of harm or discomfort to subjects as a result of their participation in the research, including physical harms, discomforts, hazards, and inconveniences as well as the potential for any social harms (e.g. loss of job or insurability due to breach in confidentiality), and for each risk listed, the magnitude (seriousness) of the risk, the probability of occurrence, and the potential duration; and
- a description of how risks will be minimized, including, if appropriate, the availability of medical or psychosocial resources that subjects might need as a consequence of the research; and
- a description of how risks to subjects are reasonable in relation to anticipated benefits.

The submission information about potential benefits must include a description of any potential benefit(s) to be gained by the individual subject as a result of participating in the research. (Payment to subjects is not considered a benefit.) If there are no direct benefits to individual subjects, a societal benefit that may result from the study must be described.

7.2.2.10 Subject Populations Information

(Revised 6/28/24)
The submission information about subject populations must include:

- Whether the expected demographic breakdown of the study population reflects either the population of Boston or the population of Boston Medical Center patients, and if not, an explanation of why not; and
- Whether limited- or non-readers will be excluded, and if so, an explanation of why they are excluded; and
- For non-exempt research, whether any member (even one) of the following vulnerable populations will be recruited:
  - Minors; and
  - Minors who are wards; and
  - Minors independently making their own healthcare decisions; and
  - Cognitively impaired individuals; and
  - Individuals with limited English proficiency; and
  - Employees, students, or trainees who are under the direct supervision of the Principal Investigator; and
  - Prisoners; and
  - Pregnant Persons; and
- Whether the following vulnerable populations will be targeted by the research:
  - Homeless individuals; and
  - Terminally ill individuals; and

- Individuals with psychiatric disorders.

If any of the above vulnerable populations are recruited or targeted, the submission must describe how informed consent will be obtained to prevent undue influence and/or coercion and how subject confidentiality will be protected. These provisions must comply with the applicable requirements in Section 9.

The submission information about other special (non-vulnerable) populations must include:

- For non-exempt research, whether even one woman of child-bearing potential will be recruited, in which case the study must comply with the applicable requirements in Section 9.4.8; and
- For studies initially submitted on or after July 1, 2019, whether even one individual will be recruited whose HIV testing status is obtained from a health care provider prior to consent, in which case the submission must include a description of how the data access plan for the study will prevent the disclosure of HIV testing status to any non-Boston Medical Center research staff prior to written consent being obtained; and
- For studies initially submitted on or after July 1, 2019, whether even one individual identified as a patient of a specialty substance use disorder clinic or provider will be recruited, in which case, the IRB will provide the Principal Investigator with both a form to be completed by all study staff and a form to be completed by an individual authorized to evaluate investigator qualifications to receive data from a substance use disorder program under 42 CFR Part 2.52; and
- For studies initially submitted on or after July 1, 2022, whether BMC inpatients or BMC outpatients or BUGSDM dental patients will be targeted by the research; and
- Whether the following students or trainees will be targeted by the research, in which case the study will be routed in the electronic system for sign off from the appropriate official (see Section 9.6):
  - Residents or fellows at Boston Medical Center; and
  - Boston University Henry M. Goldman School of Dental Medicine students; and
  - Boston University Medical students and/or Graduate Medical Sciences students; and
  - Boston University School of Public Health students.

7.2.2.11 Costs and Payment Information

(Revised 9/16/26)

The submission information about costs must include a description of the costs of research visits and procedures and who (the sponsor, the subject's insurance, or the subject) will be responsible for these costs. If any research costs will be billable to insurance, the costs to the subjects will include deductibles and co-payments. Cost of travel and/or parking should be included if the study requires additional visits beyond what would be required for standard clinical care.

The submission information about payments must include whether subjects will be reimbursed for participating in the study by money, gift certificates, coupons, etc. If subjects will be paid, the submission information must include the frequency, method, timing, and amount of payment; the total amount paid to subjects; and the plan to prorate payment for subjects who withdraw early from the study.

For research conducted at Boston University Medical Campus, subjects may be offered the option to receive payment through an electronic payment platform; the submission information must describe this option, including that the platform requires the subject to provide a Social Security Number or Individual Taxpayer Identification Number and bank account information for direct deposit, regardless of the total payment amount, and that subjects who prefer not to provide this information to the platform may instead choose to receive payment by gift card. If payments could total $2,000 or more per calendar year, the submission information must include a statement that federal tax law requires the institution to report such payments to the IRS and that subjects must provide their Social Security Number or Individual Taxpayer Identification Number to receive payment, regardless of whether payment is made through the electronic payment platform or by gift card. The submission information must also inform subjects of their right to decline payment if they do not wish to provide this tax information.

Compensation for participation in a trial offered by a sponsor may not include a coupon good for a discount on the purchase price of the product once it has been approved for marketing.

7.2.2.12 Consent Information

7.2.2.12.1 Consent Process Information

(Revised 6/23/19)
The submission information when informed consent is to be obtained from any of the subjects must include a detailed description of the informed consent process, including how and where potential subjects will be provided an opportunity to discuss the information provided to them, the individual(s) (identified by role) who will be involved in the consent discussion (see Section 8.1.3.7), and how long potential subjects will have to decide if they want to participate. If the study includes limited- and non-readers (see Section 7.2.2.10) and is greater than minimal risk, a plan must be described for using an impartial witness or for another method to assure and document that limited- and non-readers apparently understand the consequences of participating. If the study includes a formal method to assure subject comprehension that will be used for all subjects, this will satisfy the requirement for limited- and non-readers as well (see Section 8.4.6).

7.2.2.12.2 Written Documentation of Consent Information

(Revised 6/20/18)
The submission information about written documentation of consent must include whether written documentation of consent is to be obtained or whether a waiver of written documentation of consent is requested because the research meets one of the following criteria (see Section 8.4.2):

- The research presents no more than minimal risk of harm to the subjects and involves no procedures for which written consent would normally be required outside of the research; or
- The only record linking the subject to the research would be the consent document and the main risk in the research would be the potential harm because of a breach of confidentiality; or
- The subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, the research presents no more than minimal risk of harm to subjects, and there is an appropriate alternative mechanism for documenting that informed consent was obtained. This criterion is applicable for submissions approved on or after January 21, 2019.

7.2.2.12.3 Waiver or Alteration of the Consent Process Information

(Revised 5/30/17)
The submission information if a request is being made for a waiver or alteration of the consent process must include how the study meets the following five criteria (see Section 8.4.3):

- The study is not greater than minimal risk; and
- Waiving or altering the requirements for informed consent will not adversely affect the rights and welfare of study subjects; and
- The research cannot be practicably carried out without the waiver of informed consent or alteration of the consent process; and
- If the research involves using identifiable private information or identifiable biospecimens, the research cannot practicably be carried out without using such information or biospecimens in an identifiable format (for research that is submitted for initial approval on or after July 1, 2017); and
- If applicable, there is a plan to disseminate pertinent information to study subjects or legally authorized representatives after the study is completed.

7.2.2.12.4 Assent from Minors Information

(Revised 2/24/17)
The submission information if minors are enrolled in the study must include whether assent will be obtained from minors and whether and how permission will be obtained from their parents/legal

guardians. If the study involves pregnant minors, the plans for consent/assent from these subjects must be described. Plans for parent/legal guardian permission and child assent must comply with the requirements in Section 9.2.4.

7.2.2.12.5 Consent by Substituted Judgment Information

(Revised 2/24/17)
The submission information if the study involves obtaining consent from legally authorized representatives for cognitively impaired subjects must include a description of:

- The process for ascertaining the capacity of potential subjects to provide consent for themselves; and
- The process for determining who may provide consent for decisionally impaired subjects

The process for obtaining consent from decisionally-impaired subjects must comply with the requirements in Section 9.5.

7.2.2.12.6 Subjects with Limited English Proficiency Information

(Revised 5/26/26)
The submission information if the study will enroll subjects who are not fluent in English must include:

- A description of how and by whom the consent process will be conducted for subjects with limited English proficiency; and
- A description of how concerns or questions from the subjects with limited English proficiency will be addressed during the study. If the study involves more than minimal risk, provisions must be established to respond to concerns or questions of ALL subjects 24/7.; and
- A listing of any other study materials that will be provided to subjects and how they will be translated for subjects with limited English proficiency; and
- An indication of whether the study will use translated consent forms, the short form consent process, or both. If the short form consent process is requested, the submission must identify the English narrative that will be used during the consent process (which may be the entire IRB-approved English consent form). The submission must also identify any languages in which the Principal Investigator anticipates enrolling subjects, so the IRB can determine whether full translated consent forms are required for those languages per Section 8.4.5.1. Unanticipated languages do not need to be specified; if the short form process is approved, it covers all languages available in the IRB library except those identified as anticipated (see Section 8.4.5.2).

The inclusion of subjects with limited English proficiency must comply with the requirements in Section 8.4.5.

7.2.2.12.7 Consent, Assent, Permission, and Authorization Forms

(Revised 7/25/16)
Investigators must submit all consent, assent, permission, and/or authorization forms that they intend to use in the study.

7.2.2.13 Purpose Information

(Revised 2/24/17)
The submission information about the purpose of the study must include a background information, study rationale, study objective(s), and/or the hypotheses to be tested in the study.

7.2.2.14 Design/Procedure Information

7.2.2.14.1 Experimental Design Information

(Revised 5/22/22)

The submission information about the experimental design must include a detailed description of all materials and all procedures to be performed, including a clear timeline of the procedures to be performed, and which procedures/test articles are investigational and which are part of standard clinical care. This description should include:

- Methods; and
- Specific information concerning experimental interventions, such as dose and frequency of drug (and placebo) administration, or deception/debriefing process for social behavioral studies; and
- Number, frequency and duration of subject contacts (visits, telephone calls, mail outs, emails); and
- The entire duration of participation for a single subject; and
- Any additional requirements of the subject (post treatment follow-up, diary cards, questionnaires, etc.)

For multiple sites, the description should identify any procedures that will be done at any sites other than Boston Medical Center or Boston University Medical Campus. Reference may be made to surveys, questionnaires, and other data collection instruments attached to the submission.

7.2.2.14.2 Inclusion and Inclusion Criteria Information

(Revised 2/24/17)
The submission information for inclusion and exclusion criteria must include a listing of the criteria that will be used to determine whether a subject is eligible for the study, including age ranges and gender, and different criteria for different cohorts, if applicable.

7.2.2.14.3 Outcomes Information

(Revised 2/24/17)
The submission information for outcomes must include the anticipated primary outcome, any secondary outcomes, and how they will be measured.

7.2.2.14.4 Data Analysis Information

(Revised 2/24/17)
The submission information about data analysis must include a description of the plan for data analysis, including the types of comparisons planned (e.g. comparison of means, comparison of proportions, regressions, analysis of variance), which is the primary comparison/analysis, and how the analyses relate to the primary purposes of your study. If the research is qualitative, the description must state how comparisons will be made.

7.2.2.14.5 Sample Size Information

(Revised 10/02/21)
The submission information about sample size must include:

- The number of subjects (or records, specimens, or charts) enrolled in the study
  - Under the Boston Medical Center or Boston University Medical Campus Principal Investigator; and
  - Enrolled worldwide, for multi-center studies; and
- Justification for the sample size, including why the proposed sample size was chosen and the sample size calculations (or, for pilot studies, a rationale for choosing the sample size proposed, e.g. to estimate a mean to a certain accuracy, to determine if the response rate is above a certain percentage, etc.); and
- An explanation of how many evaluable subjects will be needed to answer the study question and how many subjects must be enrolled and consented to achieve this number. The IRB counts study subjects starting when they have consented; and
- A description of how the investigator will have access to a population that will allow recruitment of the necessary number of subjects. For single-site, investigator-initiated clinical trials approved on or

after May 28, 2021, this description must include quantitative data that demonstrates the feasibility of fulfilling enrollment of the sample size, as well as the service used to obtain this data.

7.2.2.14.6 Documents Used to Obtain Information from Subjects

(Revised 7/25/16)
Investigators must submit all surveys, interviews, questionnaires, focus group outlines, etc. that will be used in the study. Failure to provide this information could result in a delay in IRB review. If some of the materials are not finalized, draft versions should be submitted. The final versions will need to be approved by the IRB via an amendment prior to use.

7.2.2.15 Requirements for Data and Safety Monitoring

(Revised 10/29/24)
Investigators must provide information about their data and safety monitoring plan (DSMP) to assure that all research has an appropriate system for oversight and monitoring to ensure the safety of the participants and the validity and integrity of the data.

The DSMP must be commensurate with the risks. For minimal risk studies, the DSMP is expected to consist of the Principal Investigator indicating in the submission that Unanticipated Problems, Adverse Events, and deviations will be reported to the IRB according to IRB requirements (see Section 6.6.3).

For greater than minimal risk studies, the Principal Investigator must describe the plan for monitoring the study. Typically, studies requiring a DSMP will also be required to have a separate protocol (see Section 7.2.2.20), and the protocol will provide the necessary information about the DSMP. For greater than minimal risk studies not required to have a separate protocol, the Principal Investigator must provide a DSMP that clearly indicates:

- Expected risks to subjects; and
- Definitions of Unanticipated Problems (including expectedness and relatedness), Adverse Events, and Serious Adverse Events (may reference definitions in Section 13); and
- A description of how risks will be monitored (what is being monitored, who is monitoring, and at what frequency); and
- A description of when, by whom, and to whom Unanticipated Problems, adverse events, serious adverse events, and other safety information will be reported; and
- Responsibilities of the Principal Investigator and/or their designee for the internal monitoring of study activities; and
- Any external entities responsible for monitoring of study activities, including:
    - Independent Data Safety Monitoring Board/Data Monitoring Committee; and
    - Monitoring entity established by the Sponsor or Funding Agency; and
    - A charter that provides details about monitoring entities, including:
        - Names, titles, and affiliations of members; and
        - Member responsibilities; and
        - Meeting frequency; and
        - Interim analysis plan; and
        - Reporting plan; and
- Stopping rules.

7.2.2.16 Special Submission Requirements

7.2.2.16.1 International Research Requirements

(Revised 10/29/24)
The submission information about international research must include:

- A listing of all non-US countries where research will be conducted and plans for IRB review at each site; and

- An explanation of the relationship between the Principal Investigator and the international sites, including the funding relationship; and
- If local IRB review is being obtained, contact information and, if available, the FWA number for the local IRB sites; and
- If local IRB approval is not being obtained, an explanation of why not; and
- If local IRB approval is being obtained and the study requires translating English materials into non-English language(s) understandable to the subjects, confirmation that the local IRB will review and approve accurate translations of the English materials; and
- The plan for training the investigators and research staff at the international site(s) in human subjects research as one of the following options:
  - Investigators human subjects training will be managed by the local IRB that has responsibility for their IRB oversight; or
  - Investigators will obtain human subjects training via CITI - certificates will be provided to the IRB; or
  - Investigators will obtain human subjects training via a training program provided by the investigators from Boston Medical Center or Boston University Medical Campus - Training materials and sign-in sheets or certificates will be submitted to the IRB when available; or
  - Investigators will obtain human subjects training via alternate methods, which must be described.

Principal Investigators must confirm in the submission that they have read and will comply with the applicable institutional policies for international travel and export control.

Relevant documents must be attached to the submission as applicable, such as local IRB outcome letters, a local context review, and plans for human subjects training of international investigators.

The provisions for international research must comply with the requirements in Section 2.6.

7.2.2.16.2 Requirements for Genetic Testing, Gene Therapy, and Collecting Genetic Information

(Revised 2/24/17)

Principal Investigators must indicate in their submissions whether the proposed research involves genetic testing, gene therapy, or collection of genetic information. If so, the submission information must include:

- The classification of the genetic research component as one or more of the following:
  - Gene transfer or gene therapy (these studies require review by the Human Gene Therapy Committee, a subcommittee of the Institutional Biosafety Committee of Boston University and Boston Medical Center); or
  - Pedigree study (to discover the pattern of inheritance of a disease and to catalog the range of symptoms); or
  - Positional cloning (to localize and identify specific genes); or
  - DNA diagnostic study (to develop techniques for determining the presence of specific DNA mutations or polymorphisms); or
  - Association studies (genotype-phenotype correlation) including GWAS (genome wide association studies); or
  - Genetic pharmacokinetic research; or
  - Other (to be specified); and
- A description of the genetic component of the research; and
- Information about whether the genetic tests will be carried out in a laboratory that has received certification under Clinical Laboratory Improvement Amendments (CLIA) standards, as one of the following choices (this information must be consistent with the information provided in Section 7.2.2.7.2.3):
  - All genetic testing where results will be used for clinical decision-making or reporting to subjects and/or their clinicians will be done in a CLIA-certified lab; or
  - No genetic test results will be given to subjects or their clinicians; or
  - Other plan for genetic test results, which must be justified by the Principal Investigator; and

- Plans for use of the **samples** collected for genetic testing, either that genetic samples will be used for genetic testing ONLY for the purpose of the submitted study and all left-over genetic samples will be destroyed, or as one or more of the following:
  - Genetic samples will/may be used to develop cell lines; or
  - Genetic samples may have identifiers removed and transferred to a for-profit entity; or
  - Genetic samples will/may be saved in a repository for future genetic testing; and
- Plans for use of the **data** generated by genetic testing, either that genetic data will be used ONLY for the purposes of the submitted study, or as one or more of the following:
  - Genetic data will be made available to investigators from Boston Medical Center, Boston University, or other institutions or will be made publically available including being sent to dbGap or other central repository; or
  - Other plans for use of genetic data; and
- Plans for the identifiability of shared genetic data, as one of the following:
  - Data will retain subject identifiers (subject identifiers include names, medical record numbers, social security numbers, date of birth, other full dates, or other identifiers that would allow for deductive identification); or
  - Genetic information will ONLY be labeled with a code number. The Principal Investigator at Boston Medical Center or Boston University Medical Campus will hold the master-code linking the study ID to subject identifiers. The master-code will be stored separately from the study data and the master-code will NEVER be given to researchers outside Boston Medical Center or Boston University Medical Campus or to study sponsors; or
  - The data will be stripped of all subject identifiers before being shared; and
- If the research involves analyzing samples that already exist, information about how, where, and why the original tissue was collected; whether the samples were obtained as part of clinical care or research; whether the sample collection was approved by an IRB; and what was stated in the original consent form about secondary use of specimens; and
- A discussion of the risks and provisions to minimize risks. In genetic research, the primary risks, outside of gene therapy, are the psychological and socioeconomic risks related to generating personal genetic information (including risks to genetic relatives). If genetic results are returned to the subject, provisions for genetic counseling must be made available; and
- How the consent process will disclose plans for use of genetic samples and data and the risks from genetic research.

A Principal Investigator engaged in NIH-funded research that is subject to the NIH Genomic Data Sharing Policy must obtain consent from subjects to submit their data to an NIH repository such as the **d**ata**b**ase of **G**enotypes **a**nd **P**henotypes (dbGaP). The genomic data sharing plan submitted to NIH must be consistent with the information conveyed to all subjects in the informed consent process. For analysis of prospectively-obtained samples, the IRB will verify that the consent form to be used has appropriate language. For analysis of existing samples, the IRB will either determine that the consent language under which the samples were collected allow submission to the repository, or that subjects must be re-consented for their data to be submitted to the repository. The data must not be identifiable according to the definition of human subjects research (see Section 13) or according to the HIPAA Privacy Rule when submitted to the repository and appropriate provisions must be in place to protect the confidentiality of the key linking codes to subject identities. Any security breaches must be reported as an Unanticipated Problem to the IRB (see Section 6.6.3.2).

7.2.2.16.3 Requirements for Collection of Biological Samples

(Revised 2/24/17)
Investigators must indicate in their submissions whether the proposed research involves collection of biological samples for research purposes. If so, the submission information for each type of sample to be collected must include:

- The type of sample collected; and
- The purpose for which the sample is collected; and
- Whether the samples will be collected at the same time as clinical samples will be collected; and

- Whether the samples will be stored with identifiers (to re-contact the subjects or gain access to other information about the subjects); and
- Whether any samples will be released outside of the study team, including being sold or transferred to any third parties, and if so, what information will accompany the samples; and
- Whether remaining samples will be discarded if a subject withdraws from the study.

7.2.2.16.4 Requirements for Repositories or Retention of Samples or Data

(Revised 8/27/22)
Principal Investigators must indicate in their submissions whether the sole purpose of the research involves establishing a repository (see Section 13), or whether the research involves the retention of biological samples or data for extra use by the study investigator(s) or by other investigators. Extra use means any analysis that is in addition to that required for the study endpoints. Studies that involve retention of samples or data include:

- Incorporating a plan for retaining samples or data in an initial submission; or
- Adding a plan for retaining samples or data to an existing approved or exempt study; or
- At the completion of a research project, changing the study to a repository so that the samples or data obtained for the research can be stored for future use; or
- Collecting samples or data as part of a new or existing study to be added to a repository elsewhere (e.g. another research site, a national database, another investigator's repository).

If the sole purpose of the research involves establishing a repository, or the research involves retention of samples or data for extra use, the submission information must include:

- The purpose of retaining the samples or data and how retained samples or data will be used; and
- For research with the sole purpose of establishing a repository, reason(s) for establishing a new repository (e.g., why material cannot be obtained from commercial supplier, clinical data warehouse or clinical biobank, or established research repository operating within the institution); and
- Whether the retained samples or data are obtained directly from subjects, obtained from other sources, or both; and
- Specific details about the sources of the samples or data (e.g., name of persons or institutions providing the samples or data, IRB numbers of studies where samples or data are being collected); and
- The specific data points that will be retained, and, for sample retention, the samples that will be retained and the data elements that will be attached to the samples; and
- Whether data that contain genetic information will be retained (see Section 7.2.2.16.2); and
- The individual or organization responsible for maintaining the retained samples or data, and, if the Principal Investigator is establishing a repository, whether the task of management of the repository is being delegated to another staff member or entity such as the BU Data Coordinating Center; and
- The plans for release of samples or data, including to:
    - To whom the releases will be made (other investigators, national databases for use by multiple investigators (e.g. dbGAP), commercial entities); and
    - What information will be required to request a release; and
    - How and by whom release requests will be reviewed to ensure that the use is consistent with the consent provided by the subjects and that confidentiality protections are adequate; and
    - A description of the process for involving the appropriate parties who will execute Data Use Agreements or Material Transfer Agreements prior to release of data or samples; and
- Provisions that will be put in place to protect confidentiality of the subjects who provided the samples or data, as a choice of:
    - Coding of samples and data where all subject identifiers and the master-code/key will remain at Boston Medical Center or Boston University Medical Campus; only coded samples or data will be given to other investigators/entities; and the master-code/key will never be released to outsiders; or
    - Releasing subject identifiers to outside entities (e.g. NCI repositories) with subjects' specific consent to do so; or
    - Limiting access to subject identifiers to certain specified people; or
    - Another specified method to protect confidentiality.

- For non-exempt research with the potential for direct benefit to subjects, or for non-exempt research with optional retention of samples or data for extra use regardless of benefit, confirmation that the study team will maintain a tracking system in order to document who opted in or opted out of future use of their samples or data.
- For exempt human subjects research involving subject interaction, confirmation that the study team will maintain a tracking system in order to document who opted in or opted out of future use of their samples or data, or, confirmation that retention of samples or data for extra use is a mandatory component of the study.

7.2.2.16.5 Requirements for the Use of Ionizing Radiation

(Revised 2/24/17)

The submission information about research involving ionizing radiation must include:

- The type, quantity, frequency, and cumulative exposure from all exams or procedures involving ionizing radiation that are considered beyond standard of care; and
- The purpose of each exam or procedure including why the exposure is necessary; and
- How exposures will be minimized; and
- The text that will appear in the consent form where the radiation risk(s) are explained.

7.2.2.16.6 Requirements for Multi-Site Research Reviewed by the Boston Medical Center and Boston University Medical Campus IRB

(Revised 12/22/25)

The submission information about research that takes place at one or more external sites (sites in addition to Boston Medical Center or Boston University Medical Campus) and that will be reviewed by the Boston Medical Center and Boston University Medical Campus IRB must include:

- Information about whether there are any external investigators who will be relying on the IRB review from the Boston Medical Center and Boston University Medical Campus IRB; and
- If the Principal Investigator is the overall Principal Investigator of the entire study, is the FDA sponsor, or has responsibility for overseeing all sites:
  - For each external site:
    - The name of the external site Principal Investigator; and
    - The name of the institution; and
    - Whether the IRB of the external site will provide review or rely on the IRB review from the Boston Medical Center and Boston University Medical Campus IRB; and
  - A description of the human subjects activities being conducted by each external site; and
  - A description of the processes for communication among sites concerning information relevant to the protection of participants, such as Unanticipated Problems, interim results, and protocol modifications; and.
- For each external site relying on the Boston Medical Center and Boston University Medical Campus IRB:
  - For external sites at an institution with an FWA other than the Boston University Charles River Campus:
    - The name and FWA of the institution; and
    - The name and contact information for the institution's IRB Authorization Agreement; and
    - The CV of the external site Principal Investigator for studies submitted on or after September 1, 2019; and
  - For external sites NOT at an institution with an FWA, and for Boston University Charles River Campus faculty or staff members:
    - The name, institution (if any), contact information, and role of each member of the study team; and
    - For each role assigned to a study team member, the description of the role's tasks and duties on the study; and
    - The CV of the external site Principal Investigator for studies submitted on or after September 1, 2019; and

- Information about any Conflict of Interest of the external investigators; and
- Agreement that the Principal Investigator at Boston Medical Center or Boston University Medical Campus will comply with their oversight responsibilities.

If any external investigator will be interacting with subjects at the external site, the IRB will provide the study team with an indemnification provision for external site signature, as well as with forms for the external investigator to complete with information about local requirements, local research context issues and local ancillary reviews that are relevant to the review (see Section 2.5.2.1).

If any external study personnel are not from an institution with an FWA, the Principal Investigator is notified of their responsibility to provide a signed Individual Investigator Agreement or Collaborating Institutional Investigator Agreement, customized from a template provided by the IRB, for each listed individual.

7.2.2.17 Requirements for Not Human Subjects Research/Not Engaged

(Revised 9/15/20)
In addition to the information required Sections 7.2.2.2 and 7.2.2.3, the submission information for Not Human Subjects Research/Not Engaged must include:

- Information confirming that the study activities do not meet the definition of human subjects research at Boston Medical Center or Boston University Medical Campus; and
- If the study will only involve obtaining information that is publicly available, an explanation of why the information is publicly available and where and how the study team will obtain the information; and
- Whether activities are taking place only at Boston Medical Center and Boston University Medical Campus or whether study activities are also taking place elsewhere; and
- An explanation of the project and the study activities that are taking place at Boston Medical Center and Boston University Medical Campus.

7.2.2.18 Requirements for Relying on another IRB

(Revised 5/26/26)
In addition to the information required in Sections 7.2.2.2, 7.2.2.3, 7.2.2.4, 7.2.2.5, 7.2.2.6, and 7.2.2.8, the submission information for relying on another IRB (cede review) must include:

- The number used by the reviewing institution to identify the research; and
- Whether the reviewing IRB is:
  - A commercial institutional review board that is accredited by the Association for the Accreditation of Human Research Protection Programs (AAHRPP) and has indicated a willingness to execute a reliance agreement using SMART IRB. If the reviewing IRB is a commercial institutional review board, the submission information must include confirmation that the billing arrangement is set up so that the commercial IRB bills the sponsor directly for the IRB review costs, and documentation of the IND or IDE number; or
  - Hummingbird IRB (note that no new studies are ceded to Hummingbird IRB on or after September 1, 2019); or
  - A central institutional review board (for special multi-center research collaboration groups); or
  - Another reviewing institution; and, if so,
    - Whether the Principal Investigator will conduct research activities only at the reviewing institution or will conduct research activities at Boston Medical Center or Boston University Medical Campus; and
    - Information required for the study-specific IRB Authorization Agreement; and
- Copies of applicable documents, including the protocol, outcome letters, local context review form(s), and consent forms specific to Boston Medical Center and Boston University Medical Campus; and
- A description of the research activities that will be conducted by researchers at Boston Medical Center or Boston University Medical Campus, including:
  - Contact with subjects or their identifiable information; and

- Use of a drug, device, or surgical procedure; and
- Provisions for the consent discussion for studies involving drugs, devices, or surgical procedures; and
- Targeting of trainees at Boston Medical Center or students at Boston University Medical Campus for recruitment; and
- Recruitment of employees of Boston Medical Center or Boston University Medical Campus; and
- Recruitment of minors who are wards of the State; and
- Recruitment of cognitively-impaired subjects; and
- Recruitment of subjects with limited English proficiency, including any request to use the short form consent process; and
- Recruitment of limited- and non-readers; and
- Recruitment of Boston Medical Center inpatients, or Boston Medical Center outpatients, or Boston University Henry M. Goldman School of Dental Medicine dental patients; and
- Whether the study requires inpatient or outpatient nursing care, other than by nurses who work for the investigator or the General Clinical Research Unit, to help conduct the research. For studies that meet these criteria, a description of the commitment of nursing resources that is required for conducting the study and the plan for initial and continuing training of inpatient and/or outpatient nursing staff must be included; and
- For studies initially submitted on or after September 1, 2019, whether even one individual will be recruited whose HIV testing status is obtained from a health care provider prior to consent, in which case the submission must include a description of how the data access plan for the study will prevent the disclosure of HIV testing status to any non-Boston Medical Center research staff prior to written consent being obtained; and
- For studies initially submitted on or after September 1, 2019, whether even one individual identified as a patient of a specialty substance use disorder clinic or provider will be recruited, in which case, the IRB will provide the Principal Investigator with both a form to be completed by all study staff and a form to be completed by an individual authorized to evaluate investigator qualifications to receive data from a substance use disorder program under 42 CFR Part 2.52; and
- For studies submitted on or after March 1, 2020, whether data will be shared with a third party vendor or software application or program; and if so, whether they will use an option already-approved by Boston Medical Center or Boston University or an unapproved option. If they request to use an unapproved option, the date upon which the study team contacted the appropriate Boston Medical Center or Boston University data security office to allow for the review of the privacy and security practices of the third party.

- If applicable, justifications for any requests for an exception to Boston Medical Center and Boston University Medical Campus policies for consent, employees, wards, cognitively-impaired subjects, subjects with limited English proficiency, or limited- and non-readers; and
- For studies that are greater than minimal risk, verification of the inclusion in the consent form of appropriate language for compensation for injury, depending on whether or not the study is industry-sponsored.

The cede review submission requirements described in this section do not apply to collaborative research with Boston University Charles River Campus that falls within the scope of the global reliance agreement described in Section 2.5.2.3. For such studies, no submission to the Boston Medical Center and Boston University Medical Campus IRB is required.

7.2.2.19 Requirements for Exempt Research

(Revised 6/01/21)
In addition to the information required in Sections 7.2.2.2, 7.2.2.3, 7.2.2.4, 7.2.2.5, 7.2.2.7, 7.2.2.10, 7.2.2.11, 7.2.2.16.4, and 7.2.2.16.6, the submission information for exempt research must include:

- The exempt category applicable to the project; and
- Study procedures, including study methods, sources of data, any experimental interventions, and the duration of the study or the date ranges of the data to be collected or analyzed; and

- An estimate of the anticipated number of subjects who will be enrolled or whose records will be reviewed and a brief explanation of the selected sample size; and
- A description of any plans for screening and recruiting potential subjects and for obtaining abbreviated consent from subjects prior to participation (see Section 10.2.4.3); and
- A description of any criteria for which records will be reviewed.

7.2.2.20 Protocol Requirements

(Revised 3/2/25)
The requirement to provide detailed information about the conduct of the study must be fulfilled by attaching a separate protocol to the submission for studies that meet the definition in Section 13 of a clinical trial and that involve a medical intervention (administration of a drug or biological agent or use of a device) or surgical intervention (use of a surgical procedure) intended to modify a health outcome (effective for studies submitted on or after November 1, 2016); or, for any clinical trial (see Section 13) that is multi-site or receives NIH funding (effective for studies submitted on or after April 1, 2022); or, for any study that is required to post results on ClinicalTrials.gov (effective for studies submitted on or after March 2, 2025). For other studies, the Principal Investigator has the choice between attaching a separate protocol or completing the sections that are required for submissions without a separate protocol (Sections 7.2.2.13, 7.2.2.14, and 7.2.2.15). The IRB Director or an IRB Chair may determine that a particular study requires a separate protocol based on the nature and complexity of the study design.

For studies where a separate protocol is attached, submission information must include:
- Number of subjects under the Boston Medical Center or Boston University Medical Campus Principal Investigator; and
- A description of how the investigator will have access to a population that will allow recruitment of the necessary number of subjects; and
- Identification of whether any aspects described in the attached separate protocol do not apply to the research that will take place at Boston Medical Center or Boston University Medical Campus, such as a substudy.

7.2.2.21 Emergency Use Information

(Revised 6/29/17)
The submission information for a report of an emergency use that has already occurred of an investigational drug or device, which must be made within 5 working days of the emergency use, must include:
- A copy of the drug or device information, including the IND for investigational drugs or biologic agents; and
- The date of the emergency use; and
- The following information about the patient:
  - The patient's initials (NOT name); and
  - The diagnosis; and
  - The hospital location; and
  - The approximate age; and
  - Whether or not the patient is a child; and
- The choice of one of the following concerning the consent process:
  - Consent was obtained from the subject; or
  - Consent was obtained from the subject's legally authorized representative; or
  - Consent was not obtained; and
- If consent was obtained, a copy of the signed consent form with the patient's name redacted; and
- If consent was not obtained:
  - A written opinion by an independent physician who is not otherwise participating in the investigation that:
    1. The subject is/was confronted by a life-threatening situation necessitating the use of the test article; and

2. Informed consent cannot/could not be obtained because of an inability to communicate with, or obtain legally effective consent from, the subject; and
3. Time is/was not sufficient to obtain consent from the subject's legal representative; and
4. No alternative method of approved or generally recognized therapy is/was available that provides an equal or greater likelihood of saving the subject's life; and

- When the opinion of the independent physician was obtained in writing:
  - Prior to the use of the test article; or
  - Up to 5 days after the use of the test article, in which case, the investigator must convey the opinion in the submission that immediate use of the test article was required to preserve the subject's life, and time was not sufficient to obtain an independent physician's determination that the four conditions above apply; and
- The name of the independent physician; and
- The date when the independent physician provided the written opinion; and

- A description of the reason why conventional therapy/treatment could not be used; and
- How the costs of the test article will be paid; and
- Relevant attachments (including either the consent form or the written opinion of the independent physician, as applicable).

7.2.2.22 Individual Patient IND Information

(Revised 2/24/17)

The submission information for studies that involve an individual patient IND must include:

- A brief clinical history of the patient (without patient name or other identifiers), including diagnosis, disease status, prior therapy, response to prior therapy, the rationale for requesting the proposed treatment, including a list of available therapeutic options that would ordinarily be tried before the investigational drug or an explanation of why use of the investigational drug is preferable to use of available therapeutic options; and
- A description of the risks of the investigational drug, measures to minimize the risks, and a discussion of whether risks are reasonable in relation to anticipated benefits; and
- Whether the proposed patient is a minor; and
- An explanation of how informed consent will be obtained and by whom; and
- Who will dispense the drug; and
- How costs for the drug will be paid; and
- Relevant attachments, including:
  - All related communications with the FDA including FDA approvals; and
  - Reference(s) providing justification for the proposed use of the drug; and
  - The consent form.

The emergency use must comply with the requirements of Section 12.3.

7.2.2.23 Humanitarian Use Device Information

(Revised 2/24/17)

The submission information for studies that use a Humanitarian Use Device must include:

- A description of the rare disease or condition for which the device is to be used, the proposed indication(s) for use of the device and the reasons why such treatment is needed; and
- A description of the device and a discussion of the scientific rationale for use of the device for the rare disease or condition; and
- A description of the risks of the device, measures to minimize the risks, and a discussion of whether risks are reasonable in relation to anticipated benefits; and
- Whether any proposed patients will be minors; and
- The proposed treatment plan, describing how the device will be applied/inserted, under what circumstances (e.g. surgery, anesthesia, by whom, etc.), expected time patient will have/use the device and how the device will be monitored, and including any screening procedures and any patient follow-up visits, tests, or procedures.
- How costs for the device will be paid; and

- Relevant attachments, including:
  - All related communications with the FDA including FDA approvals; and
  - The product labeling; and
  - The patient information packet; and
  - Authoritative references, to demonstrate that the device meets the definition of a Humanitarian Use Device.

7.3 Signatures Required

7.3.1 Investigator Signatures

(Revised 4/21/23)
Certain actions (initial submissions, amendments, progress reports, internal study personnel changes, reportable events and new information, protocol exceptions), when created in the electronic system, require the electronic signature of the Principal Investigator in order for them to be submitted to the IRB. This electronic signature is obtained when the Principal Investigator logs into the electronic system using their own username and password and then makes the submission.

The Principal Investigator may designate a proxy to make submissions to the IRB if the Principal Investigator will be unable to access the electronic system for a period of time. The proxy must be a co-investigator on the study who is familiar with the study and has appropriate training, background, and credentials to serve in the Principal Investigator's absence. The proxy is added as an Alternate Signoff in the Principal Investigator's account in the electronic system. When the Principal Investigator indicates that they are not available to review submissions for signoff, notifications will be sent to the proxy. As soon as the Principal Investigator again has access to the electronic system, the Principal Investigator must remove the proxy.

Requests to change the contact information in one or more approved consent form or other approved subject materials (see Section 7.4.1.3), requests where the only change is to approve promotional recruitment materials (see Section 7.4.1.4), or submission of final reports (see Section 7.4.4) do not require the electronic signature of the Principal Investigator for submission. Therefore these reports may be submitted by any study investigator or research staff member who has been granted read/write privileges for the study by the Principal Investigator. It is the expectation of the IRB that these reports are reviewed by the Principal Investigator before they are submitted to the IRB. The Principal Investigator is accountable for all materials presented to the IRB via the electronic system for an individual study.

7.3.2 Department Chair or Section Chief Signatures

(Revised 3/2/25)
Each new IRB submission must be signed off by a Department Chair or Section Chief. The Principal Investigator identifies who is responsible for signing off on their submission in the electronic system. The electronic system automatically routes the submission after the Principal Investigator signs off to this Department Chair or Section Chief for electronic signature.

It is the responsibility of the Principal Investigator to know who is responsible for signing off on their submissions. Principal Investigators who do not know who should be signing off on their submissions must contact their department administrators.

Principal Investigators who are the Department Chair or Section Chief cannot sign off on their own submissions. The submission must identify the person designated to sign off on this Chair's/Chief's research. This person may be the Department Chair or the Dean. Department Chairs or Section Chiefs who are co-investigators on a study may sign off on the submission.

If the person responsible for signing off is NOT listed in the electronic system, then the Principal Investigator must contact the IRB office to have that person's name added to the system.

Department Chairs and Section Chiefs (and all other persons assigned to a signoff role in the electronic system) have the ability to designate a proxy to sign off on IRB submissions if they will be unable to access the electronic system or otherwise be unable to sign off for a period of time. The proxy must have the appropriate background and credentials to serve in the absence of the Department Chair or Section Chief. The proxy is added as an Alternate Signoff in the Department Chair's/Section Chief's account in the electronic system. When the Department Chair/Section Chief indicates that they are not available to review submissions and sign off, notifications will be sent to the proxy. As soon as the Department Chair/Section Chief again is able to sign off, the Department Chair/Section Chief must remove the proxy.

The following statement appears above the Department Chair's/Section Chief's signature:

By selecting "Approve and providing my electronic signature on this certification, I am certifying that:

1. I am the Department Chair/Section Chief for the department where this study/protocol will be conducted; and
2. The study/protocol is appropriate to be conducted in the department; and
3. The Principal Investigator has adequate expertise in the subject matter and in research; and
4. The research staffing is appropriate; and
5. The research will not interfere with patient care; and
6. The standard of care described in the protocol reflects the standard of care in the department; and
7. The research can and should be conducted within this department.

7.3.3 Other Signatures (Special Routing)

(Revised 9/16/22)

The basic information required for all submissions includes identifying any features of the research that require special routing for review which is done automatically in the electronic system (see Section 7.2.2.2). Each entity provides the IRB with the name of the individual(s) to whom the signoff responsibility is assigned.

The special routing is for the purpose of making the assigned individuals aware that a study with special features is being submitted to the IRB, so that they can begin their own separate processes for review and/or approval. Signoff does not mean that the submission is approved, simply that the assigned individuals acknowledge that they are aware of the proposed study. In the case where a submission was routed in error, because of a mistake in the submission, the assigned individuals will acknowledge the submission with comments indicating that their review does not apply, rather than disapproving which would require re-submission and re-routing to all other individuals who had already signed off.

If assigned individuals have questions or concerns about the study, they have the options of disapproving the submission with an explanation of what changes might be needed for signoff, of waiting to sign off until the concerns are resolved through contacting the Principal Investigator, or of acknowledging with comments for the IRB and if appropriate also contacting the Principal Investigator to ask for clarifications or changes. The Principal Investigator must submit any changes that are required by an assigned individual after signoff, either during the initial review or as a subsequent amendment request.

The assigned individual is notified by the system when a study requiring signoff is submitted, and reminded every three days until the signoff is completed. After a submission has been waiting for signoffs for seven days, the Principal Investigator will be notified with instructions on how to check who has not signed off and a suggestion that contacting this individual may speed up the submission.

The IRB office confirms that the submissions have received all the required signoffs prior to approval, exempt determination, or ceding review. IRB approval does not constitute approval by other persons or institutional committees and it is the responsibility of the Principal Investigator to ensure that all necessary approvals have been obtained prior to beginning the study (e.g., approval of the Human Gene Therapy Committee).

7.4 Submissions after Initial Approval

7.4.1 Requirements for Amendment Submissions

7.4.1.1 Requirements for Changes to Study Personnel

(Revised 1/29/22)
Requests to change study personnel are made using the Internal Study Personnel Changes form, except that requests to add an external site or change the Principal Investigator at an external site where the Boston Medical Center and Boston University Medical Campus is acting as the IRB of Record requires a change to the study application and must be submitted using the Change Request & Amendments form (see Section 7.4.1.2). The submission information must include a brief description of the names and roles of the personnel to be added or removed from the study and appropriate changes to the Key Study Personnel section of the submission.

If the request is for a change to the Principal Investigator and/or the Supervising Principal Investigator of the study, the submission information must include the status of the study and an acknowledgement by the new Principal Investigator and/or Supervising Principal Investigator that they understand and accept the responsibilities for this study listed in Section 6.6.1. The acknowledgement may be an electronic (pdf) copy of an email from the new Principal Investigator or Supervising Principal Investigator, or the acknowledgement may be a scanned copy of the responsibilities signed by the new Principal Investigator or Supervising Principal Investigator, or the acknowledgement may be an electronically signed attestation in the electronic system that confirms that they will comply with the responsibilities.. For changes to the Principal Investigator, edited versions of the consent form and other study materials with the new Principal Investigator's name and contact information must also be submitted if additional subjects will be consented.

7.4.1.2 Requirements for Changes to the Study Application, Protocol, Consent Forms, or Study Documents

(Revised 10/29/24)
Requests to change the information contained in the study application, protocol, consent forms, and/or study documents other than promotional recruitment material are made using the Change Request and Amendments form for studies that previously were approved, ceded to an external IRB, or determined to be exempt or Not Human Subjects Research. Changes to approved consent forms or other approved subject materials consisting solely of changes to contact information may instead be submitted as part of a request to change the Principal Investigator (see Section 7.4.1.1) or using the Contact Information Change Request form (see Section 7.4.1.3). Requests for approval of promotional recruitment materials may be submitted using the Recruitment Materials Submission form (see Section 7.4.1.4). The submission information for all other changes must include a detailed description of the proposed changes, an explanation of why the changes are necessary, a statement about whether or not the currently-approved consent form contains any information that is changed by the proposed amendment, and a description of any plans for re-consenting subjects. The Principal Investigator also must make any necessary changes to the application information (see Section 7.2.2) and provide any modified protocol and new or modified consent forms or other attachments. If the protocol is provided in a non-editable format (such as a pdf), an additional document must be provided with each change to the protocol tracked in comparison to the already-approved version ("redlined").

The Principal Investigator of a multi-site study is responsible for submitting a Change Request & Amendment form with appropriate changes to the application (see section 7.2.2.16.6) when adding an external site for which the Boston Medical Center and Boston University Medical Campus IRB is serving as the IRB of record.

7.4.1.3 Requirements for Changes to Contact Information

(Revised 12/14/17)

Requests to change the contact information in one or more approved consent form or other approved subject materials are made using the Contact Information Change Request form, unless the change is required because of a change in the Principal Investigator (see Section 7.4.1.1). The submission information must include the revised documents in an editable format, a description of the proposed changes, and an indication of the choice for notifying already-enrolled subjects of the new contact information (in addition to general plans such as call forwarding or providing the new phone number in a voicemail message for the old phone number):

- No subjects have ever been enrolled; or
- No previously-enrolled subjects will have any additional study visits, phone calls, or mailings; or
- Previously-enrolled subjects will be notified of the new contact information at their next study visit, phone call, or mailing; or
- Another method will be described for notifying subjects.

7.4.1.4 Requirements for Submission of Promotional Recruitment Materials

(Revised 10/29/24)
Requests where the only change is to approve promotional recruitment materials are made using the Recruitment Materials Submission form. The submission information must include the new or revised materials. If the materials require review by the Boston University Chobanian & Avedisian School of Medicine Communications, the Goldman School of Dental Medicine Communications Office, Boston University School of Public Health Communications, or the Boston Medical Center Communications and Marketing Department according to their policies for review of promotional recruitment materials, the submission information must include the approval document from the communications office that reviewed and approved these materials.

7.4.2 Submission of Protocol Exceptions

(Revised 2/24/17)
Requests for protocol exceptions (planned, single departures from the IRB approved protocol) are made using the Protocol Exception Form. The submission information must include a description of the exception; a justification of the request; a statement about any changes to the risk/benefit ratio of the study and/or any need for a modified consent form for the single subject; and information about any required notification to the sponsor or funding agency.

7.4.3 Submission of Progress Reports and Study Status Check-In Reports

7.4.3.1 Submission of Progress Reports for Studies with Expiration Dates

(Revised 6/28/24)
Requests to continue research that was approved or given an exempt determination with an expiration date are made using the Continuing Review Submission Form.

The submission information for renewal of approved research must include:

- Study status:
  - Study does not enroll subjects or collect records; or
  - Intending to enroll but no one has yet been enrolled/had their records collected,
  - Actively enrolling; or
  - Closed to enrollment/interventions still proceeding; or
  - Closed to enrollment/interventions complete, collection of ongoing data that is part of routine clinical care is still proceeding; or
  - closed to enrollment/interventions and follow-up complete, analysis of identifiable data is still in progress; and
- Subject enrollment:
  - Number enrolled; and
  - Number enrolled using the Short Form for consenting subjects with limited English proficiency; and

    - Whether or not subject demographics match the intended population; and
- Monitoring or auditing reports; and
- A summary of adverse events and serious adverse events that have occurred since the last progress report, either through the attachment of a report from a Data Safety Monitoring Board or Data Monitoring Committee, or through a summary prepared for the progress report, including, if any adverse events have occurred, a statement that the pattern of adverse events, in total, does not suggest that the research places subjects or others at a greater risk of harm than was previously known; and
- A summary of minor deviations; and
- If the study involves an investigational drug, confirmation that the most recent version of the Investigator's Brochure has been submitted to the Boston Medical Center and Boston University Medical Campus IRB; and
- Study progress:
    - Subjects found ineligible after consent, withdrawn or lost to follow up, and terminated; and
    - Subject complaints and how they were resolved; and
    - Funding changes; and
    - Data identifiability status; and
    - Any information that suggests a change in risks or identification of new risks.

The submission information for continuing exempt research that was given an exempt determination (prior to January 21, 2019) with an expiration date must include:

- Study status:
    - Research activities are continuing as described in the most recent submission (initial submission or any amendments previously determined to be exempt); or
    - Research activities are continuing; some changes have been made since the most recent submission that do not alter the exempt determination, in which case, these changes must be described; or
    - Research activities are no longer occurring.

7.4.3.2 Submission of Study Status Check-In Reports for Studies without Expiration Dates

(Revised 10/29/24)
The information required for the status update of studies approved or given an exempt determination without an expiration date and for ceded studies is provided using the Status Check-In Report form.

The submission information for study status check-in for studies approved without an expiration date must include:

- Study status:
    - Research activities are continuing as described in the most recent submission (initial submission or any amendments previously submitted and approved); or
        - Changes have been made since the most recent submission that were not reported to the IRB, in which case, the associated Reportable Events and New Information form and Change Request and Amendment form must be listed; or
    - Research activities are no longer occurring (in which case, the information from Section 7.4.4 must also be submitted); and
- A summary of any minor deviations or subject complaints; and
- Number of subjects enrolled using the Short Form for consenting subjects with limited English proficiency.

The submission information for study status check-in for studies given an exempt determination without an expiration date must include:

- Study status:
    - Research activities are continuing as described in the most recent submission (initial submission or any amendments previously determined to be exempt); or

- Research activities are continuing; some changes have been made since the most recent submission that do not alter the exempt determination, in which case, these changes must be described; or
- Research activities are no longer occurring. If research activities are no longer occurring, the form will direct the Principal Investigator to close the study within the electronic system by changing the study status to closed (see Section 6.6.6) instead of proceeding with the submission of the Status Check-In Report form.

The submission information for study status check-in for studies ceded to another IRB must include:

- Study status:
  - Research activities are continuing and all changes required to be reported to the Boston Medical Center and Boston University Medical Campus IRB (see Section 2.5.4) have either:
    - been submitted; or
    - are being submitted with the status check-in submission; or
  - Research activities are no longer occurring. If research activities are no longer occurring, the form will direct the Principal Investigator to submit a Final/Closure Report Form (see Section 7.4.4) instead of proceeding with the submission of the Status Check-In Report form.

7.4.4 Submission of Final Reports

(Revised 2/24/26)
Requests to close a non-exempt or ceded study are made using the Final/Closure Report Form.

The submission information for closure of approved research must include: study status (never started or closed); enrollment; demographics; auditing or monitoring results; adverse events, deviations, and subject complaints; closure processes (including plans for destroying or anonymizing study data and whether data or specimens will be moved into a repository); and new risks. If the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record for external sites, the submission must include confirmation that human subjects research activities have ceased at all relying sites.

The submission information for closure of ceded research must include: study status (never started or closed); enrollment; demographics; and provision of the site closure letter from the reviewing IRB.

7.4.5 Submission of Reportable Events and New Information

(Revised 12/22/23)
Reports of Unanticipated Problems, major deviations, and safety monitors' reports with required changes or recommended changes involving subject safety are submitted using the Reportable Events and New Information Form. Submission information for all reports must include the date the event occurred, the date the Principal Investigator became aware of the event, and either a description of required changes to the research or an explanation of why no changes are necessary.

Additional required information for reporting Unanticipated Problems is a description of the event, whether the Unanticipated Problem was internal or external, and confirmation that the event constitutes an Unanticipated Problem (see Section 6.6.3.2).

Additional required information for reporting major deviations and changes made to eliminate an apparent immediate hazard to subjects is:

- A description of the deviation or change; and
- A description of why this deviation constitutes a major deviation or change made to eliminate an apparent immediate hazard to subjects (see Section 6.6.5.2); and
- Identification of whether the deviation resulted in an Unanticipated Problem (reported on the same form). If the report is for an unapproved change made to eliminate an apparent hazard to subjects, the incident or finding that indicated the apparent immediate hazard would usually meet the definition of an Unanticipated Problem that should be reported to the IRB; and

- The Corrective and Preventative Action plan describing how to avoid a recurrence of such deviations. For changes made to eliminate an apparent immediate hazard, any plan for amending the protocol should be described.

Additional required information for reporting safety monitors' reports with required changes or recommended changes involving subject safety (see Section 6.6.3.3) are a description of the changes, the plan to carry out the changes, identification of whether the requirements or recommendations were made because of an event qualifying as an Unanticipated Problem (reported on the same form), and the report from the safety monitor.

7.4.6 Administrative Closure of Pending Review Responses

(New 7/20/26)
A Review Response is the electronic form documenting the stipulations the Principal Investigator must address before the IRB can complete its review, issued when a submission is returned for corrections or additional information. The IRB may issue a Review Response, with accompanying stipulations, for any submission type accepted in the electronic system.

Following issuance of a Review Response, the electronic system generates automated reminder notifications to the Principal Investigator and study team contacts at the following intervals:

- Sixty (60) days from the date the Review Response was returned; and
- Six (6) months from the date the Review Response was returned; and
- Fifteen (15) months from the date the Review Response was returned (final notice).

If a Review Response remains pending eighteen (18) months after the date the IRB returned it to the study team, the IRB administratively closes the submission.

The operational effect of administrative closure depends on the submission type and the status of the parent study:

- Administrative closure of an Initial Review submission results in withdrawal of the submission and closure of the study; or
- Administrative closure of a Final Report results in processing of the closure based on the information submitted, and the study is closed; or
- Administrative closure of a Continuing Review form, Reportable Events and New Information form, Internal Study Personnel Change form, Protocol Exception form, Recruitment Materials Submission form, or Contact Information Change Request form results in withdrawal of the submission; the study's status is unaffected; or
- Administrative closure of a Change Request and Amendment form to an active study results in withdrawal of the submission, and the study application reverts to the most recently approved version; the study remains active; or
- Administrative closure of a Change Request and Amendment form or Continuing Review form to a closed study results in withdrawal of the submission without reverting the study application.

8 Consent and Authorization

8.1 Requirements for Informed Consent

8.1.1 Consent in Non-Exempt Human Subjects Research

(Revised 1/17/18)
Principal Investigators may not involve a human being as a subject in non-exempt human subjects research without obtaining the legally effective informed consent from the person, from the person's Legally Authorized Representative (see Section 9.5), or from the parent(s)/legal guardian(s) of a child subject (see Section 9.2.4), unless the requirement for informed consent has been waived or altered by the IRB (see Section 8.4.3).

Unless the IRB has waived the requirement for written documentation of consent under Section 8.4.2, the subject, Legally Authorized Representative, or parent(s)/legal guardian(s) must sign and date the consent form, as must the person conducting the consent discussion (this last signature is mandatory for initial submissions on or after November 1, 2016).

The required elements of informed consent are listed in Section 8.2. These elements have been incorporated into the consent form templates that are found on the IRB website.

8.1.2 Consent in Exempt Human Subjects Research and Not Human Subjects Research

(Revised 2/24/17)
Studies that are determined to be not human subjects research or exempt by the IRB are not required to incorporate all of the elements of informed consent listed in Section 8.2. "Abbreviated consent" requirements for exempt studies that involve interactions with subjects are listed in Section 10.2.4.3.

8.1.3 Consent Process Requirements

8.1.3.1 Inclusion of Required Elements of Consent

(Revised 8/30/16)
All non-exempt research studies are required to have a consent process and consent forms that contain all of the applicable elements of consent listed in Section 8.2 unless the IRB approves a waiver or alteration of consent (see Section 8.4.3).

8.1.3.2 Request for a Waiver or Alteration of the Consent Process

(Revised 12/14/17)
To request a waiver of informed consent for a study or a waiver or alteration of certain elements of consent for a study, the Principal Investigator must clearly describe how all five of the criteria listed in Section 8.4.3 are met. If the request is for an alteration of consent, the submitted consent form should be consistent with the requested alteration.

8.1.3.3 Request for a Waiver of Written Documentation of Consent

(Revised 1/17/18)
To request a waiver of the requirement for documentation of informed consent, the Principal Investigator must clearly describe how one of the three criteria listed in Section 8.4.2 are met. The submitted consent form should be consistent with the requested waiver.

8.1.3.4 Consent for Screening

(Revised 9/16/26)
If the Principal Investigator plans a screening process that involves obtaining information from individuals by intervention or interaction, a screening consent process is required. If the screening involves any clinical procedures (i.e., a procedure involving a physical intervention, specimen collection, or more than minimal physical risk, such as a blood draw, imaging study, or fasting), the consent for screening must include all of the elements listed in Section 8.2 unless the study qualifies for a waiver or alteration of the consent process under Section 7.2.2.12.3. This consent for screening must also include a HIPAA authorization if PHI is used unless the study qualifies for a waiver or alteration of authorization under Section 8.5.2.2. The consent for the screening activities may be included as part of the full consent process for the study or may be done separately, prior to the main consent process. If the screening does not involve any clinical procedures, a modified screening consent process may be used where the information is limited to a short summary of the study, a description of the screening tests and their foreseeable risks, and how the data will be used and kept confidential. Screening consent templates are available on the IRB website.

For research not eligible for equivalent protections approved prior to January 21, 2019 (see Section 2.1.2), the IRB makes a determination that the modified screening consent process meets the criteria listed in Section 8.4.3 for a waiver or alteration of informed consent. For research eligible for equivalent protections approved prior to January 21, 2019 and for all research approved on or after January 21, 2019, formal findings for a waiver are not required if the screening consent process conforms to the criteria in the above paragraph.

8.1.3.5 Request to Use a Non-Standard Consent Format

(Revised 11/18/19)
The IRB may allow the use of consent forms that do not follow the consent form template for studies with consent forms approved by the Boston Veterans Administration Medical Center (VAMC), for multi-site studies where the sponsor or single IRB has provided a consent form, and for studies where no subjects will participate at Boston Medical Center or Boston University Medical Campus.

Consent forms that are reviewed by the Boston Medical Center and Boston University Medical Campus IRB and the VAMC IRB but where subjects are enrolled and consented only at the VAMC are not required to be submitted in the standard format. In these cases the Principal Investigator submits the VAMC IRB-approved consent forms as an attachment in the electronic system. As part of its review of the study, the IRB will confirm that the VAMC IRB-approved consent forms contain all of the elements required by 45 CFR 46.116(a) and (b), and 46.116(c) (if reviewed on or after January 21, 2019) and by 21 CFR 50.25(c) if applicable.

For multi-site studies where an external sponsor or single IRB has provided a non-exempt consent form to be used with subjects at Boston Medical Center or Boston University Medical Campus, the IRB may accept the content and organization of that consent form in lieu of the consent form template. The Principal Investigator must submit a consent form where the following basic information is listed on the first page: project title; IRB number (the number assigned in the Boston Medical Center and Boston University IRB electronic system); the name of the sponsor(s); the name, email, and address of the Principal Investigator; and study-related phone number(s), including a 24-hour number if the study is greater than minimal risk (required for initial submissions on or after November 1, 2016).

The non-exempt consent form should use template language for the costs section and for the compensation for injury section as reviewed by the appropriate grants office. In addition, if a HIPAA authorization is required, it must include Boston Medical Center and Boston University among the organizations with access to PHI. If the sponsor's consent form includes language about the Genetic Information Nondiscrimination Act (GINA) and the research will take place in Massachusetts, the GINA language must be edited to include the Massachusetts-specific information (see Section 8.2.4).

Consent forms for studies where all subjects will participate at an institution other than Boston Medical Center or Boston University Medical Campus are not required to follow the consent form template, but must comply with all of the requirements in Section 8.2.

For exempt research, when the Boston Medical Center and Boston University Medical Campus IRB is not the IRB of record, any exempt consent documents are not required to comply with the requirements in Section 10.2.4.3; instead, they must comply with the requirements of the IRB of record.

The IRB retains the authority to require changes to consent forms as necessary to comply with regulatory and institutional requirements.

8.1.3.6 Consent for Follow-Up after Subject Withdrawal

(Revised 3/21/17)
Subject withdrawal may occur when a subject decides to withdraw or when a subject is asked to withdraw from a study. Research staff may ask such subjects for permission to access their follow-up information collected in the future during the course of regular medical care. Permission may be incorporated into the initial consent form or may be obtained by a separate consent and HIPAA authorization form. A template

consent and HIPAA authorization form for follow-up after subject withdrawal is posted on the IRB website. The Principal Investigator must submit the customized version of the form for IRB approval, either with the initial submission or as an amendment, before using it with any subject. If a subject does not consent to follow-up, the research staff may not access any medical records, but may consult public records, such as those establishing survival status.

8.1.3.7 The Individuals Who Must be Involved in the Informed Consent Process

(Revised 10/20/23)
Study team members who will meet with prospective subjects, conduct the consent discussion, or obtain informed consent must be sufficiently trained on the consent process and be sufficiently knowledgeable about the research protocol to be able to discuss the study and answer questions posed by the subject. Documentation of specific training for staff delegated the responsibility of conducting the informed consent discussion must be maintained in the study files.

For studies initially submitted on or after September 1, 2019 that involve drugs, devices, or surgical procedures, the consent process must, unless an exception is approved by the IRB, include having the discussion of the purpose, risks, benefits and alternatives carried out by a Licensed Independent Practitioner (LIP, for example, physician, dentist, physician assistant, nurse practitioner). For the purposes of this policy, LIP shall mean an individual permitted by Massachusetts law and by Boston Medical Center to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. Residents and fellows do not qualify as LIPs unless they have been issued a full license that allows them to practice medicine independently and they are members of the Medical-Dental Staff. If an LIP is required to be involved in the consent discussion, their involvement must be documented by either: 1. the LIP signing the consent form as the person who conducted the consent discussion or by 2. documenting in an informed consent progress note a brief summary of the consent process, noting the involvement of the LIP. The IRB may approve a consenting process for studies involving drugs, devices, or surgical procedures submitted on or after September 1, 2019 that does not involve discussion of the purpose, risks, benefits and alternatives by an LIP if the investigator provides a justification that satisfies IRB that the proposed consenting process will protect the rights, safety and welfare of potential research subjects.

8.2 Elements of Informed Consent

8.2.1 Basic Requirements for Informed Consent

8.2.1.1 General Requirements for Informed Consent

(Revised 6/20/18)
Consent information provided to potential subjects for research initially approval on or after January 21, 2019 must:

- Provide the information in sufficient detail that a reasonable person would want to have in order to make an informed decision about whether to participate in the study; and
- Organize and present the information in a way that facilitates understanding of why one might or might not want to participate; and
- Begin with a concise and focused presentation of the key information that is most likely to assist in understanding the reasons why one might or might not want to participate in the research.

The prospective subject, Legally Authorized Representative, or parent(s)/legal guardian(s) must be provided with sufficient opportunity to discuss the information provided to them and to consider whether or not to participate in the research. The consent process must minimize the possibility of coercion or undue influence. The information that is given to the subject, Legally Authorized Representative, or parent(s)/legal guardian(s) shall be in language understandable to the subject, Legally Authorized Representative, or parent(s)/legal guardian(s). Consent information must not include exculpatory language (statements that the subject waives or appears to waive any legal rights or provides a release from liability for negligence).

8.2.1.2 Basic Elements of Informed Consent

(Revised 6/29/17)

The following are the basic elements of informed consent that must be provided to each subject unless the IRB has waived or altered the consent process under Section 8.4.3:

- A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental; and
- A description of any reasonably foreseeable risks or discomforts to the subject; and
- A description of any benefits to the subject or to others that may reasonably be expected from the research; and
- A disclosure of appropriate alternative procedures or courses of treatment, if any, which might be advantageous to the subject; and
- A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained and that notes the possibility that the IRB, the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the sponsor (and others, as appropriate) may inspect the records; and
- For research involving more than minimal risk, an explanation as to whether any compensation and/or 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; and
- An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject; and
- A statement that participation is voluntary, that refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and that the subject may discontinue participation at any time without penalty or loss of benefits to which the subject is otherwise entitled.

If the research involves an investigational drug (see Section 12.1) or device (see Section 12.2), the consent form must state that when a subject withdraws, data collected up to the point of withdrawal remains part of the study database and may not be removed.

If the research involves collection of identifiable private information or identifiable biospecimens, the consent form must include one of the following two statements (for research submitted for initial approval on or after July 1, 2017):

(i) A statement that identifiers might be removed from the identifiable private information or identifiable biospecimens and that, after such removal, the information or biospecimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or

(ii) A statement that the subject's information or biospecimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

If the research is being performed according to the standards of the International Conference on Harmonisation-Good Clinical Practices (ICH-GCP), the following additional elements are required:

- The probability of random assignment (if applicable); and
- The subject's responsibilities; and
- The important potential benefits and risks of any appropriate alternative procedures or courses of treatment; and
- A statement that the subject's Primary Care Provider will be informed of their participation in the research, unless specifically requested not to do so by the subject.

8.2.2 Additional Elements of Informed Consent

(Revised 8/27/22)

The following are additional elements of informed consent that must be provided to each subject when inclusion of this information is appropriate for the study:

- A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) which are currently unforeseeable; and
- Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent (this is required for research being performed under ICH-GCP); and
- Any additional costs to the subject that may result from participation in the research; and
- The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject; and
- A statement that significant new findings developed during the course of the research which may relate to the subject's willingness to continue participation will be provided to the subject (this is required for research being performed under ICH-GCP); and
- The approximate number of subjects involved in the study (this is required for research being performed under ICH-GCP); and
- Plans, if any, for re-contacting subjects after the study has been completed (for initial submissions on or after November 1, 2016); and
- A statement stressing the voluntariness of participation if any patients of any study investigator may be recruited, similar to the following (the consent form templates found on the IRB website will incorporate the most recent approved version of this language):

  Your doctor/your child's doctor may also be an investigator in this research study. Being an investigator means your/your child's doctor is interested in both you/your child and the study. You may want to get a second opinion about your/your child being in the study. You can do so now or at any time during the study. Another doctor who is not an investigator can give you a second opinion about being in the study. You do not have to agree to be/have your child be in this study even though it is offered by your/your child's doctor; and
- The possibility, if any, that the research may lead to the development of drugs, tests, or procedures that might have commercial value and the plans for sharing any money if products are developed from the research (for initial submissions on or after November 1, 2016).
- For research being performed under ICH-GCP, the written informed consent must be signed and personally dated by the subject or by the subject's legally acceptable representative, and by the person who conducted the informed consent discussion.

8.2.3 Requirements for Statements about Confidentiality

(Revised 1/17/18)

The consent process must clearly disclose what information will be requested, what confidentiality protections are in place (see Section 9.7.2), and what risks remain despite those protections. If there are any situations where identifiable information would be revealed outside the research context (such as mandated reporting of suspected abuse or neglect of children, the elderly, or disabled persons; reporting of communicable diseases; and acting on information received about potential harm to self or others), this information must be included during the consent process. The consent form templates found on the IRB website include appropriate language to communicate these confidentiality protections.

8.2.4 Elements of Informed Consent for Research Involving Genetic Testing or Genetic Research

(Revised 2/24/17)

When a study involves genetic testing or genetic research, required additional elements of informed consent are:

- Plans for future use of genetic samples and genetic data; and
- The psychological and socioeconomic risks related to generating personal genetic information (including risks to genetic relatives); and
- The plans for return of pertinent and incidental findings (see Section 8.2.6), or a statement that no findings will be returned to subjects.

If the Principal Investigator plans to submit genetic data to an NIH repository such as **d**ata**b**ase of **G**enotypes **a**nd **P**henotypes (dbGaP), the plans for future use should include a statement similar to the following:

> Samples that are collected from you in this study will be analyzed to find out information about your genetics. Your genetic and health information, without your name or other data that could easily identify you, will be put in a database run by the National Institutes of Health (NIH). Other researchers can ask the NIH to get your information from the database. You should know that it is possible that your genetic information might be used to identify you or your family, though we believe it is not too likely that this will happen. Once your information is given to the NIH database, you can ask to have NIH stop sharing it, but NIH can't take back information that was already shared.

If the results of genetic testing will be returned to subjects, and in other circumstances as determined by the IRB, the additional element of informed consent is the inclusion of the following statements:

> There is a potential risk that your genetic information could be used to your disadvantage. For example, if genetic research findings suggest a serious health problem, that could be used to make it harder for you to get or keep a job or insurance. Both Massachusetts state laws and federal laws, particularly the Genetic Information Nondiscrimination Act (GINA), generally make it illegal for health insurance companies, group health plans, and most employers to discriminate against you based on your genetic information. These laws will generally protect you in the following ways:
> 1. Health insurance companies and group health plans may not request your genetic information that we get from this research.
> 2. Health insurance companies and group health plans may not use your genetic information when making decisions regarding your eligibility or premiums.
> 3. Massachusetts employers with 6 or more employees (or 15 or more employees in other states, under GINA) may not use your genetic information that we get from this research when making a decision to hire, promote, or fire you or when setting the terms of your employment.
>
> Be aware that neither Massachusetts law nor GINA protects you against genetic discrimination by companies that sell life insurance, disability insurance, or long-term care insurance. Thus, life insurance, disability insurance, and long-term care insurance companies may legally ask whether you have had genetic testing and deny coverage for refusal to answer this question.

8.2.5 Elements of Informed Consent for Research Involving Repositories or Retention of Samples or Data

(Revised 6/01/21)

These requirements apply to studies with the sole purpose of establishing a repository and to studies involving retaining samples (biological specimens with associated data) or data that will be retained for extra use by the study investigators or by other investigators. Extra use means any analysis that is in addition to that required for the study endpoints (see Section 7.2.2.16.4). The consent or abbreviated consent process must include:

- How samples or data will be obtained; and
- What types of research the samples or data will be used to investigate; and
- Whether genetic information is included; and
- Plans for release of samples or data, including:
  - What types of researchers may request release (from Boston Medical Center or Boston University, external institutions, industry, government, etc.); and
  - Who will review requests for release to ensure the research is consistent with the aims of the repository; and
  - What sample or data handling procedures the recipient researchers will be required to agree to; and
  - For release of samples, what information will accompany the samples (demographics, diagnosis, etc.); and

- A description of the standard operating procedures for protecting subject confidentiality, including storage and sharing of samples or data.

If the study has the potential for direct benefit to the subject, the Principal Investigator must make agreeing to sample or data retention optional; that is, the potential subject can agree to participate in the main study but not allow the retention of their data or samples.

8.2.6 Elements of Informed Consent Concerning Communication of Pertinent and Incidental Findings

(Revised 8/11/19)

When a study involves communicating pertinent and/or incidental findings to subjects and/or their physicians (see Section 7.2.2.7.2.3), the required additional elements of informed consent are:

- The anticipated findings that will be communicated and/or the criteria that will be used to determine which findings will be communicated if there may be unanticipated pertinent and/or incidental findings; and
- To whom and by whom the findings will be communicated, when, and how; and
- The reliability and limitations of the information provided by the any findings that are not standard measurements; and
- If applicable, any further diagnosis or other actions that may be required based on the findings, including their risks and costs to the subject (and to their relatives if applicable); and
- Whether or not subjects can request not to have some or all of the findings returned to themselves or to their physicians, and if so, the categories of findings they can choose and the considerations relevant to making those choices; and
- If applicable, the resources such as counseling available to subjects to help with receiving and interpreting the findings.

If applicable, a statement similar to the following may be included when pertinent research findings may be returned, either as a stand-alone paragraph or incorporated into the study-specific discussion:

> The research measurements we make are not necessarily the same as tests done by your doctor. We are collecting information on many people to answer our research questions. Not everyone doing the research tests is a doctor or a nurse. You or your doctor should not rely on the research measurements to make any diagnosis, treatment, or health planning decisions. If you or your doctor decides that follow-up tests and treatments are necessary, then you or your insurance will be billed for the costs.

If applicable, a statement similar to the following may be included when incidental findings from imaging may be returned, either as a stand-alone paragraph or incorporated into the study-specific discussion:

> The imaging test you will have in this study is for research purposes only. However, we might see something that could be important to your health. If we do, we will ask you if you want us to explain what we noticed. If you would like, we will also tell your doctor. You or your doctor should not rely on the research measurements to make any diagnosis, treatment, or health planning decisions. If you or your doctor decides that follow-up tests and treatments are necessary, then you or your insurance will be billed for the costs.

If applicable, a statement similar to the following may be included when no findings will be returned to subjects or their physicians:

> The tests we are doing in this study are for research purposes only. We will not tell you the results because it is not known if they mean anything.

8.3 Review of Informed Consent Process

8.3.1 Ensuring Completeness

(Revised 8/11/19)

The IRB reviews submitted consent forms to assess whether they meet the requirements in Section 8.2 for non-exempt research and in Section 10.2.4.3 for exempt research. For funded research, the Boston Medical Center Clinical Trial Office or the Boston University Office of Sponsored Programs verifies that the consent form description of provisions for medical care for subjects with a research-related injury conforms to the applicable grant or contract (see Section 6.7), as well as clinical trial billing rules, if applicable. Required changes to the consent forms are sent to the Principal Investigator via the electronic system. The Principal Investigator is required to make any required changes and resubmit the consent forms via the electronic system.

8.3.2 Consent Validation

(Revised 2/24/17)
Once the study is approved the electronic system automatically validates the consent form. The validated consent form contains, as part of the footer, the approval date for the study.

Investigators must only use consent forms that are listed under Approved Consent in the electronic system. Unapproved consent forms must never be used to obtain consent from subjects.

8.3.3 Retention of Signed Consent Forms

(Revised 11/29/16)
All signed informed consent forms must be retained after the end of the study for a minimum of 7 years by the Principal Investigator. Some studies will require that all study documents be retained for a longer period of time (see Section 6.6.7.1). It is the responsibility of the Principal Investigator to be aware of and comply with all of the regulatory and sponsor requirements for record retention for each study.

When a subject signs more than one consent form or signs a consent form addendum (because of changes to the study requiring re-consent), all signed forms must be retained.

8.4 Informed Consent Determinations

8.4.1 Written Consent

(Revised 6/28/24)
Informed consent must be documented on an approved consent form unless these requirements are specifically waived or modified by the IRB according to Section 8.4.2. The consent form must be signed and dated by the subject, their Legally Authorized Representative, or parent(s)/legal guardian(s). The consent form must be signed and dated by the person conducting the consent discussion unless the study is no greater than minimal risk and the consent form is provided remotely, such as electronically or by mail, and the consent process satisfies the requirements in Section 10.1.1.2.7. The subject must be given or offered a copy of the consent form, unless this requirement is specifically waived or modified by the IRB.

Subjects who are physically unable to provide a signature on a consent form may provide consent or assent by requesting another person to sign in their presence. The person signing the form on behalf of the subject must be an adult and may not be the person conducting the consent discussion. The person signing the form on behalf of the subject must provide a statement to this effect on the page with their signature, such as “[Name] is unable to sign and has directed me to sign in their presence – [printed name of person signing].” When subjects who are unable to sign are subjects with limited English proficiency, limited- or non-readers, and/or decisionally impaired persons, the additional consent requirements in Section 8.4.5, Section 8.4.6, and/or Section 9.5, respectively, must also be followed.

8.4.2 Waiver of Documentation of Consent

(Revised 6/20/18)
The IRB may waive the requirement for the Principal Investigator to obtain a signed consent form for some or all subjects if the IRB finds and documents that the research meets one of the following criteria:

- 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 in confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subjects' wishes will govern; or
- 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; or
- The subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, the research presents no more than minimal risk of harm to subjects, and there is an appropriate alternative mechanism for documenting that informed consent was obtained. This criterion is applicable for submissions approved on or after January 21, 2019.

The IRB will review the written description of the information that will be provided to subjects. When the IRB determines that a study meets the criteria for a waiver of documentation of consent, study-specific justifications will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. If consent is waived entirely under Section 8.4.3, the IRB will not additionally determine that documentation can be waived. In cases in which the documentation requirement is waived, the IRB may require the Principal Investigator to provide subjects with a written copy of the consent document. Waiver of documentation of consent is an IRB determination that appears in the outcome letter.

8.4.3 Waiver or Alteration of Consent

(Revised 8/15/20)
The IRB can approve a request for waiver or alteration of the informed consent procedure either at a convened IRB meeting or by the expedited procedure. A waiver of informed consent means that the research subjects are not made aware that they or their data are being used for research. An alteration of informed consent means that one or more required elements of consent (see Section 8.2) are missing or incomplete. However, for research approved on or after January 21, 2019, the IRB may not approve an alteration that omits or alters the requirements in Section 8.2.1.1.

In order to qualify for waiver or alteration of informed consent the research study must fulfill **all** of the following (five) criteria

- The research must present no more than minimal risk of harm to subjects; and
- The waiver or alteration will not adversely affect the rights and welfare of the subjects; and
- The research could not practicably be carried out without the waiver or alteration; and
- If the research involves using identifiable private information or identifiable biospecimens, the research could not practicably be carried out without using such information or biospecimens in an identifiable format (for research submitted for initial approval on or after July 1, 2017); and
- Whenever appropriate, the subjects will be provided with any additional pertinent information after participation.

Non-exempt research involving analysis of existing identifiable data without the subjects' consent requires a waiver of consent. Research involving deception or incomplete disclosure requires a waiver or an alteration of informed consent. Deception can be a complete absence of informing subjects that they are part of a research project, or can be actively providing subjects with misinformation about some aspect of the research procedures. Incomplete disclosure involves leaving out of the consent process certain information in order to control some aspect of the subjects' experiences. All five criteria must be met for either deception or incomplete disclosure.

In assessing whether the waiver or alteration will adversely affect the rights and welfare of the subjects, the IRB will consider:

- For waiver of consent (no consent is obtained):
  - When there is no interaction with subjects (analysis of identifiable information), whether the confidentiality protections are adequate to minimize the risk of disclosure outside of the research context; and

  - When there is interaction with subjects (“secret shopper” type studies), whether the interactions that the subject has with the researcher are typical of their usual activities and whether confidentiality protections are adequate; and
  - Whether providing information about the study after it has been completed is appropriate.
- For alteration of consent (consent is obtained without providing the subject with complete information):
  - Whether subjects might not have agreed to participate if the withheld information had been provided at the time of consent; and
  - Whether subjects might find out something about themselves they would rather not know by participating; and
  - Whether the process for debriefing (revealing the deception or incomplete disclosure) is timely and provides subjects with the opportunity to decline to have their data used in the research.

FDA is in the process of changing its regulations to allow waiver or alteration of consent for minimal risk clinical investigations under FDA jurisdiction, in addition to planned emergency research (see Section 8.4.4.2) and emergency use of an investigational drug, biologic, or device (see Section 12.3.3). The FDA provided guidance dated July, 2017 that it will not object to a sponsor initiating, or an investigator conducting, a minimal risk clinical investigation for which the IRB finds and documents that the waiver or alteration of informed consent meets the requirements described in this section.

Prior to July, 2017, the IRB granted some waivers of consent for research involving in vitro diagnostic devices if the research met the following criteria that FDA has established for clinical investigations qualifying for “enforcement discretion”:

- The investigation meets the IDE exemption criteria for in vitro diagnostic devices (see Section 12.2.5); and
- The study uses leftover specimens, that is, remnants of specimens collected for routine clinical care or analysis that would have been discarded. The study may also use specimens obtained from specimen repositories or leftover specimens that were previously collected for other research purposes; and
- The specimens are not individually identifiable, i.e., the identity of the subject is not known to and may not readily be ascertained by the investigator or any other individuals associated with the investigation, including the sponsor. If the specimen is coded, it will be considered to be not individually identifiable if neither the investigator(s) nor any other individuals associated with the investigation or the sponsor can link the specimen to the subject from whom the specimen was collected, either directly or indirectly through coding systems; and
- The specimens may be accompanied by clinical information as long as this information does not make the specimen source identifiable to the investigator or any other individual associated with the investigation, including the sponsor; and
- The individuals caring for the patients are different from and do not share information about the patient with those conducting the investigation; and
- The specimens are provided to the investigator(s) without identifiers and the supplier of the specimens has established policies and procedures to prevent the release of personal information; and
- The study meets all other criteria for approval in Section 10.1.1.1.

When the IRB determines that a study meets the criteria for a waiver or alteration of consent, study-specific justifications will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. Waiver or alteration of consent is an IRB determination that appears in the outcome letter.

8.4.4 Waiver of Consent for Planned Emergency Research

8.4.4.1 Emergency Research Consent Waiver

(Revised 2/24/17)

The IRB may approve an Emergency Research Consent Waiver for more than minimal risk research activities that will be carried out on human subjects who are in need of emergency therapy and for whom, because of the subjects' medical condition and the unavailability of legally authorized representatives of the subjects, no legally effective informed consent can be obtained.

The IRB may approve research 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 a consultant to the IRB and who is not otherwise participating in the research) finds and documents each of the following:

1. 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.
2. 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 involved in the research or clinical 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 research or clinical investigation.
3. 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 related evidence support the potential for the intervention to provide a direct benefit to the individual subjects; and
    iii. risks associated with the research or intervention 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.
4. The research or clinical investigation could not practicably be carried out without the waiver.
5. The proposed research protocol or 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.
6. The IRB has reviewed and approved informed consent procedures and an informed consent document in accord with Section 8. 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 research or clinical investigation consistent with paragraph (7)(v) below.
7. 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 research or clinical investigation will be conducted and from which the subjects will be drawn;
    ii. public disclosure to the communities in which the research or clinical investigation will be conducted and from which the subjects will be drawn, prior to initiation of the research or clinical investigation, of plans for the research or investigation and its risks and expected benefits;
    iii. public disclosure of sufficient information following completion of the research or 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 research or 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 the family member objects to the subject's participation in the research or 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.

In addition, 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 research or clinical investigation, the details of the research or clinical 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 the subject's participation may be discontinued 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 research or 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 the research or clinical investigation with waived consent and the subject dies before a legally authorized representative or family member can be contacted, information about the research or clinical investigation is to be provided to the subject's legally authorized representative or family member, if feasible.

For the purposes of this waiver "family member" means any one of the following legally competent persons: spouses; parents; children (including adopted children); brothers, sisters, and spouses of brothers and sisters; and any individual related by blood or affinity whose close association with the subject is the equivalent of a family relationship.

8.4.4.2 Planned Emergency Research Subject to FDA Regulations

(Revised 8/30/16)
Any planned emergency research that uses a drug or device is subject to regulations from the FDA in addition to the requirements in Section 8.4.4.1. An IND or IDE that describes the emergency use is required for these studies (See Sections 12.1 and 12.2).

To approve planned emergency research subject to FDA regulations, the IRB must find that it meets the criteria in Section 8.4.4.1. The IRB determinations and documentation will be retained by the IRB for at least 3 years after completion of the clinical investigation (see Section 4.4.2), and the records shall be accessible for inspection and copying/printing by the FDA (see Section 4.4.1).

If an IRB determines that it cannot approve a clinical investigation because the investigation does not meet the criteria in Section 8.4.4.1 or because of other relevant ethical concerns, the IRB must document its findings and provide these findings promptly in writing to the clinical investigator and to the sponsor of the clinical investigation. If the Principal Investigator is also the sponsor of the clinical investigation, the Principal Investigator must promptly disclose this information to FDA and to any other clinical investigators who are participating or are asked to participate in this or a substantially equivalent clinical investigation sponsored by the Principal Investigator, and to other IRB's that have been, or are, asked to review this or a substantially equivalent investigation by that Principal Investigator.

8.4.5 Planned Inclusion of Subjects with Limited English Proficiency

(Revised 12/05/25)
The Principal Investigator must indicate in the initial submission whether subjects are expected to be enrolled who have limited English proficiency (see Section 7.2.2.10). If so, the appropriate special protections for speakers with limited English proficiency must include a plan to provide a translation of the full consent form in each anticipated language (see Section 8.4.5.1), or include a plan to use the short form written consent document (see Section 8.4.5.2).

In addition, the submission must describe the plans for conducting the consent process, communicating with subjects with limited English proficiency in emergency situations, interpreting during study visits, and obtaining translations of additional study materials. The IRB will review the submission to assess whether the plans are adequate to ensure that a truly informed, legally effective consent is obtained and to assess whether communication between the research staff and subjects throughout the research will protect the safety and welfare of subjects and the integrity of the research data.

The following apply to the consent process for the inclusion of subjects with limited English proficiency (see Sections 8.4.5.1, 8.4.5.2, and 8.4.5.3):

- All provisions for "subjects" in Section 8.4.5, 8.4.5.1, 8.4.5.2, and 8.4.5.3 equally apply to parents/legal guardians providing permission (see Section 9.2.4) and to Legally Authorized Representatives providing consent (see Section 9.5).
- Informed consent materials must be presented in language understandable to the subject.
- Consent must be documented in writing unless waived by the IRB (see Sections 8.4.2 and 8.4.3).
- Whenever possible, documentation must be in the form of an informed consent written in a language understandable to the subject that embodies all elements of informed consent (see Section 8.2).

8.4.5.1 Use of Translated Consent Forms

(Revised 12/05/25)

Full translated consent forms should be used for the anticipated enrollment of potential subjects with limited English proficiency. After the English versions of initial and revised versions of the consent forms and other study materials have been approved by the IRB, the Principal Investigator must submit non-English versions that have been prepared by a qualified translator. The Translator Qualification form can be found on the IRB website. The exception to the requirement to submit translated materials and the Translator Qualification form to the Boston Medical Center and Boston University Medical Campus IRB is when the study is conducted internationally and the Principal Investigator confirms that the translated documents will be reviewed and approved by the local IRB (see Section 7.2.2.16.1). In this instance, the translated documents do not need to be submitted to the Boston Medical Center and Boston University Medical Campus IRB.

The IRB review of whether the translators have adequate qualifications will consider what medical background, if any, would be appropriate based on the risks and complexities of study interventions, and based on whether any of the study procedures are procedures that require additional consent when performed for clinical care.

Unless written documentation of consent has been waived (see Section 8.4.2), the translated consent form must be signed by the subject and by the person conducting the consent discussion. A copy of the translated consent form must be given to the subject.

8.4.5.2 Use of Short Form Consent Process

(Revised 5/26/26)

The IRB may approve the use of a short form written consent document for obtaining consent from incidental, unanticipated potential subjects with limited English proficiency. When enrollment of subjects with limited English proficiency is anticipated, the process in Section 8.4.5.1 should be followed instead of using the short form. However, the IRB has the discretion to allow the use of the short form if the number of anticipated subjects with limited English proficiency is few, if requiring the Principal Investigator to provide a translation of the full consent form would be unduly burdensome, and if the IRB determines that the short form consent process will adequately protect the rights and welfare of potential subjects with limited English proficiency.

The information required to request approval to use the short form process in an initial submission or in an amendment request is listed in Section 7.2.2.12.6. The submission must include an English narrative

that will be translated to the subject, which may be a separate document or the entire IRB-approved English consent form. If the English narrative is not the IRB-approved English consent form, it must include appropriate signature lines for the person conducting the consent discussion and for the witness (see Section 8.4.5.3).

When the IRB approves the use of the short form process for a study, this approval covers all languages for which the IRB maintains a pre-translated short form in its library. The investigator is not required to specify individual languages in advance. The IRB may exclude specific languages from short form approval when enrollment of subjects speaking those languages is anticipated at the study site, in which case a full translated consent form is required for those languages per Section 8.4.5.1. If a subject is encountered whose language is not available in the IRB library, the investigator must obtain a certified translation of the short form and submit it for IRB approval prior to use.

The short form must be signed by the subject (or legally authorized representative) and the witness. The English narrative describing the study must be signed by the witness and the person conducting the consent discussion. If the contracted interpreter telephone line is used, the interpreter may direct the person conducting the consent discussion to record their interpreter identification number on the witness signature line in lieu of a physical signature.

A copy of the translated short form and English narrative must be given to the subject.

The short form consent process may be used no more than three times for the same language in a given study, unless otherwise approved by the IRB. After three uses of the short form in a given language, the Principal Investigator must obtain a full translation of the IRB-approved consent form in that language and submit it for IRB approval before enrolling additional subjects who speak that language (see Section 8.4.5.1). Upon IRB approval of the translated consent form, the Principal Investigator must offer a copy of the translated consent form to any active subjects previously enrolled using the short form who speak that language.

For greater than minimal risk research, after any use of the short form consent process, the Principal Investigator must obtain a full translation of the IRB-approved consent form into the subject's language and submit it for IRB approval within 30 days of that subject's enrollment. Once approved, the translated consent form must be promptly offered to the subject. The IRB may waive or modify this requirement if the Principal Investigator demonstrates that obtaining a full translation would be impracticable (e.g., a rare language for which certified translation services are unavailable or prohibitively expensive, or a single unanticipated subject in a study nearing completion).

Each short form consent document includes a cover page with instructions for the research team, which is not distributed to subjects.

The determination that short form use is allowed will be will be recorded in the minutes for approvals by the convened IRB and in the electronic system for approvals by the expedited procedure. The IRB will approve a copy of the short form(s) in the approved language(s). The outcome letter will state that the short form consent process has been approved for use with all languages available in the IRB library, will identify any languages excluded from short form approval for which full translated consent forms are required, and will note that the consent form must include the witness signature block.

Progress reports and study status check-in reports ask whether any subjects have been enrolled using the short form consent process, and if so, how many and in what languages, so that the IRB can consider whether the pattern of short form use indicates that the Principal Investigator should anticipate further enrollment of subjects with limited English proficiency (see Section 10.1.2).

8.4.5.3 Witnesses and Interpreters for Subjects with Limited English Proficiency

(Revised 5/26/26)

For subjects with limited English proficiency, the consent process must be verbally translated into a language understandable to the subject. This requirement applies regardless of whether the full translated consent form or the short form is used.

The IRB review of required qualifications for interpreters, including whether adult family members may serve as interpreters, will consider what medical or dental background, if any, would be appropriate based on the risks and complexities of study interventions, and based on whether any of the study procedures are procedures that require additional consent when performed for clinical care. Minors may not serve as interpreters. Boston Medical Center policy does not allow untrained individuals to be interpreters during medical encounters. Interpreters from Boston Medical Center and the Henry M. Goldman School of Dental Medicine interpreter services, including the contracted interpreter telephone line, will be considered to have sufficient training and expertise for interpreting studies with any medical or dental procedures.

If translated consent forms are used, a witness to the consent process is not required, unless the potential subject is a limited- or non-reader (see Section 8.4.6). If the potential subject is a limited- or-non-reader, the witness must be fluent in both languages and not otherwise associated with the study. If an interpreter is used who is not associated with the study, then the interpreter can serve as the witness.

If the short form is used, a witness who is present throughout the consent process is required. The witness must be fluent in both English and the language of the subject. If the verbal translation is provided by the individual who is also conducting the consent discussion during the short form consent process, then a witness who is fluent in both languages and not otherwise associated with the study is required. If an interpreter is used who is not associated with the study, then the interpreter can serve as the witness.

8.4.6 Informed Consent for Limited- and Non-Readers

(Revised 3/2/25)
Note that all provisions for “subjects” in this section equally apply to parents/legal guardians providing permission (see Section 9.2.4) and to Legally Authorized Representatives providing consent (see Section 9.5).

Potential subjects are considered to be limited- or non-readers when they ask to have the consent form read to them during the consent process or otherwise verbally indicates that they are having difficulty reading the consent form.

Limited- and non-readers should be included in studies unless the IRB determines that their exclusion is justified. Unless the exclusion of limited- and non-readers is determined to be justified by the IRB, studies that are greater than minimal risk must either include a plan to have an impartial witness who is present throughout the consent process or propose some other method, such as a quiz or a “teach-back” process, to ensure comprehension. This latter approach can be used when consent is obtained just from limited- or non-readers, or can be used for all subjects. If the research is being performed according to the standards of the International Conference on Harmonisation - Good Clinical Practices, an impartial witness is required for obtaining consent from limited- and non-readers. Minors may not serve as witnesses.

The consent process must fully communicate information required for the potential subject to provide informed consent. If a witness is used, the witness must sign a statement on the consent form that the form was read to and apparently understood by the subject (unless documentation of consent is waived by the IRB under Section 8.4.2). If an alternative method to ensure subject comprehension is described in the submission (see Section 7.2.2.12.1), there must be an appropriate plan for documenting the method, such as on the consent form or in the study records.

The Principal Investigator must indicate in the submission whether limited- or non-readers are expected to be enrolled (see Section 7.2.2.10). The IRB will review the submission to assess whether there are

adequate provisions for communication between the research staff and subjects throughout the research to protect the safety and welfare of subjects and the integrity of the research data.

When limited- and non-readers are recruited, the signature of the witness or of the person conducting the consent discussion (if there is an alternative method to ensure subject comprehension) is considered written documentation of consent.

When the IRB determines that the exclusion of limited- and non-readers is justified, the consent form should not include the phrase "(or it has been read to you)" in the text above the subject signature line and should not include a witness signature line.

The determination of the IRB that limited- or non-readers are excluded will be recorded in the minutes for approvals by the convened IRB, and will appear as an IRB determination in the outcome letter.

8.5 Authorizations under HIPAA

8.5.1 Authorization to Use and Disclose PHI

(Revised 8/16/17)
When a study involves obtaining the subject's authorization for the use or disclosure of PHI under HIPAA (see Section 13 for the definition of PHI), Principal Investigators are encouraged to combine the authorization with the consent form, so that subjects will sign a single form. If a separate authorization form is used, this form does not have to be reviewed by the IRB, but it is the responsibility of the Principal Investigator to ensure that the form of authorization is acceptable to the entity providing the PHI. The IRB will review authorizations that are submitted for a "Not Engaged" determination for certain recruitment activities (see Section 2.4).

Authorizations reviewed by the IRB must be written in plain language and must include:

- A description of the information to be used or disclosed that identifies the information in a specific and meaningful fashion; and
- The name or other specific identification of the person(s), or class of persons, authorized to make the requested use or disclosure; and
- The name or other specific identification of the person(s), or class of persons, to whom the covered entity may make the requested use or disclosure; and
- A description of each purpose of the requested use or disclosure; and
- An expiration date or an expiration event that relates to the individual or the purpose of the use or disclosure. The statement "end of the research study," "none," or similar language is sufficient if the authorization is for a use or disclosure of PHI for research, including for the creation and maintenance of a research database or research repository; and
- A place for the signature of the individual and date. If the authorization is signed by a personal representative of the individual, a description of such representative's authority to act for the individual must also be provided; and
- Statements adequate to place the individual on notice of all of the following:
    - The individual's right to revoke the authorization in writing, and any exceptions to the right to revoke and a description of how the individual may revoke the authorization; and
    - The consequences to the individual of a refusal to sign the authorization and assurance to the subject that the provision of treatment will not be conditioned on signing the authorization (and clarifying that participation in the research project and any procedures that are solely research-related are conditioned on the subject signing the authorization); and
    - The potential for information disclosed pursuant to the authorization to be subject to redisclosure by the recipient and no longer be protected by HIPAA.

The consent form templates found on the IRB website include a section containing HIPAA authorization language.

8.5.2 Use and Disclosure of PHI Without Authorization

8.5.2.1 Limited Data Sets

(Revised 2/24/17)
A Principal Investigator may provide information in the IRB submission as described in Section 7.2.2.3 that access to PHI without a signed authorization from the subject is required, but that the PHI meets the definition of a Limited Data Set (see Section 13 for the definition of Limited Data Set). The IRB is not required to approve a waiver of authorization for use or disclosure of a Limited Data Set. The Principal Investigator is expected to enter into a Data Use Agreement with the covered provider of the Limited Data Set. The Data Use Agreement will describe the ways in which the information in the Limited Data Set may be used as part of the study and how it will be protected.

8.5.2.2 Waiver or Alteration of Authorization for Use and Disclosure of PHI

(Revised 8/11/19)
A Principal Investigator may request according to Section 7.2.2.3 that the IRB approve an alteration to or a waiver of, in whole or in part, the individual authorization required under HIPAA for use or disclosure of PHI that does not qualify as a Limited Data Set (see Section 13 for the definitions of PHI and Limited Data Set). When the Principal Investigator is also requesting that a different IRB serve as the IRB of record (see Section 7.2.2.18), for studies submitted prior to September 1, 2019, the IRB of record will be responsible for considering the waiver request under their policies (see Section 2.5.3) and for studies submitted on or after September 1, 2019, the Boston Medical Center and Boston University Medical Campus IRB will be responsible for considering the waiver request.

The Boston Medical Center and Boston University Medical Campus IRB may approve the waiver request either at a convened meeting under Section 10.2.1 or by the expedited procedure under Section 10.2.2. The criteria for determining that authorization may be altered or waived are:

- The use or disclosure of PHI involves no more than a minimal risk to the privacy of individuals, based on, at least, the presence of the following elements:
  - An adequate plan to protect the identifiers from improper use and disclosure; and
  - An adequate plan to destroy the identifiers at the earliest opportunity consistent with conduct of the research, unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law; and
  - Adequate written assurances that the PHI will not be reused or disclosed to any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of PHI would be permitted without authorization; and
- The research could not practicably be conducted without the waiver or alteration; and
- The research could not practicably be conducted without access to and use of the PHI.

In order for PHI from Boston Medical Center or Boston University to be released without authorization for studies where Boston Medical Center and Boston University Medical Campus are not engaged in the research (see Section 2.4), the IRB that grants the waiver of authorization must be the Boston Medical Center and Boston University Medical Campus IRB. To request the waiver of HIPAA authorization, an employee or agent of Boston Medical Center or Boston University must submit a request for a “Not Engaged” determination (see Section 10.2.6), including a request for the waiver of HIPAA authorization (see Section 7.2.2.3).

When the IRB determines that a study meets the criteria for a waiver or alteration of authorization for use or disclosure of PHI, the following will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB:

- A brief description of the PHI for which the IRB has determined use or access is necessary to the research; and
- Documentation that the waiver or alteration was reviewed under the convened IRB or the expedited procedure, according to the policies and procedures of the Boston Medical Center and Boston University Medical Campus IRB; and

- Study-specific justifications for why the waiver or alteration of authorization meets the applicable criteria.

9 Special Populations

9.1 Considerations for Special Populations

(Revised 8/30/16)
Certain additional safeguards are required for the special populations listed in this section, particularly with respect to minimizing risks, obtaining informed consent, and managing confidentiality.

9.2 Children

9.2.1 Inclusion of Children in Research

(Revised 6/29/17)
The definition of a child is given in Section 13: "Children are defined as persons who have not attained the legal age for consent to treatments or procedures involved in the research." The IRB will verify from official sources about the legal age of consent in the jurisdiction(s) where the research will take place if there is any uncertainty. All studies which involve, or will potentially involve, children must be identified at the time of submission to the IRB. If children are to be added as study subjects after initial IRB approval, then the Principal Investigator must submit an amendment describing how the children will be involved in the research and the potential risks and minimization of risks to these subjects.

9.2.2 Child Research Approval Categories

(Revised 8/11/19)
In all non-exempt research approved to involve children as subjects, the research must be classified into one of the four following categories. The study-specific justifications for the category under which the research was approved will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. The outcome letter will state the approval category for child research.

The four categories of research involving children are based on degree of risk and benefit to the individual subjects:

- **Category 1** (45 CFR 46.404; 21 CFR 50.51)**:** Research that involves no greater than minimal risk; or
- **Category 2** (45 CFR 46.405; 21 CFR 50.52): Research that involves greater than minimal risk but presents the prospect of direct benefit to the individual subjects. Category 2 can only be approved if (1) the risk is justified by the anticipated benefit to the subjects **and** (2) the relation of the anticipated benefits to the risk is at least as favorable to the subjects as that presented by available alternative approaches; or
- **Category 3** (45 CFR 46.406; 21 CFR 50.53)*:* Research that involves greater than minimal risk with no prospect of direct benefit to individual subjects. Category 3 research can only be approved if (1) the risk represents a minor increase over minimal risk; (2) 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** (3) the intervention or procedure is likely to yield generalizable knowledge about the subjects*'* disorder or condition which is of vital importance for the understanding of the subject's condition; or
- **Category 4** (45 CFR 46.407; 21 CFR 50.54)**:** Research that does not fall into one of the three above categories, but which the IRB determines presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children. Research in this category cannot be approved by the IRB without the approval of the Secretary of HHS or the Commissioner of Food and Drugs.

Only research in Category 1 can be initially approved by the expedited review procedure since research must present *no more than minimal risk* to qualify for expedited initial review. Amendments that represent

minor changes in previously approved research may be approved by the expedited review procedure for research in all categories.

9.2.3 Children Who are Wards

(Revised 5/27/16)
For children who are wards of the Massachusetts Department of Children & Families, either parental permission must be obtained for enrolling their children in research or the Department of Children & Families must obtain prior judicial approval for enrolling the children when the parents cannot be located, or when the children are in custody for surrender for adoption or for termination of parental rights.

Children who are wards of the state or any other agency, institution, or entity can be included in research approved under Category 3 or 4 (greater than minimal risk with no prospect of direct benefit) only if such research is:

- Related to their status as wards; or
- Conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

For such research, the IRB will 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.

9.2.4 Assent and Permission

9.2.4.1 Requirements for Assent and Permission

(Revised 8/11/19)
For non-exempt research approved to involve children as subjects, the study must include procedures for obtaining the assent of the child, if appropriate, as well as the permission (consent) of the parent(s) or legal guardian(s), unless waived under Section 8.4.3. When parents/legal guardians are not English speakers and/or are limited- or non-readers, the additional consent requirements in Section 8.4.5 and/or Section 8.4.6, respectively, must also be followed.

9.2.4.2 Obtaining Consent when Enrolled Minors are No Longer Children

(Revised 2/24/17)
When minors enrolled in a study no longer meet the definition of a child (usually, because they have reached the age of majority), consent must be obtained from these subjects as adults for continued participation in the study or from the subjects' Legally Authorized Representatives for subjects who are do not have the capacity to consent (see Section 9.5). Principal Investigators must include a description of how and when such consent will be obtained in their IRB submissions.

9.2.4.3 Child Assent

(Revised 2/24/17)
Assent refers to the child's agreement and must be solicited by the person conducting the consent discussion with the parent(s)/legal guardian(s) when the child is capable of being consulted about participation in the research. The capability of a child to assent depends on the complexity of the research and the child's age, maturity, and psychological state. To elicit assent, the child must be provided with a fair explanation of what participation involves, and should be told that they may decline to participate even if their parent or guardian has given permission. Children aged 2 or older who are not capable of assent due to age and/or cognitive ability should still be given an explanation appropriate to their level of understanding.

The IRB may waive the requirement for assent if the interventions or procedures involved in the research hold out the prospect of direct benefit that is important to the health or well-being of the children and are available only in the context of the research, or under circumstances in which consent may be waived under Section 8.4.3.

Documentation of assent should be provided by the signature of the person conducting the assent discussion on the parent permission form. Children with reading skills sufficient to understand the permission form (ages 16 and 17) may sign the form. For new submissions on or after November 1, 2016, the Principal Investigator must provide a justification to use a separate assent information form signed by the child. The IRB may waive the requirement for documentation of assent under circumstances in which documentation of consent may be waived under Section 8.4.2.

9.2.4.4 Minors Making Their Own Health Care Decisions

(Revised 6/29/17)
In some instances a minor is legally allowed to consent on their own behalf without parental involvement. In this instance, the minor does not fit the definition of a child in Section 13 because the minor has the legal authority to consent to the treatments or procedures involved in the research. One example of this would be a pregnant minor, who has been independently making treatment decisions for herself, may be allowed to consent to research without the permission of her parent(s). This determination is made by the IRB on a case by case basis.

9.2.4.5 Parental Permission

(Revised 2/24/17)
As part of its review the IRB determines whether the permission of one parent or two parents (or legal guardians) is required. When the IRB requires permission of two parents, the permission of one parent is sufficient if the other parent is deceased, unknown, incompetent, or not reasonably available, or if only one parent has legal responsibility for the care and custody of the child. When the IRB requires permission of two parents, “not reasonably available” will be specified by the IRB to mean either “the other parent is not present during the consenting process” [generally appropriate for Category 1 (minimal risk) and Category 2 (direct benefit)] or “not able to be contacted by phone, email, or mail” [generally appropriate for Category 3 (minor increase over minimal risk) and Category 4 (greater than minimal risk)].

For Categories 1 and 2, the permission of one parent is usually sufficient (although the IRB may, at its discretion, require the signature of two parents). For Categories 3 and 4 the permission of two parents is required for research not eligible for equivalent protections (see Section 2.1.2). For research eligible for equivalent protections, the IRB may determine that the permission of only one parent is required for Category 3 (minor increase over minimal risk), based on the risks, benefits, and best interests of the subjects.

The IRB may waive or alter the requirements for parental permission under Section 8.4.3 and/or for written documentation of consent under Section 8.4.2 for minimal risk (Category 1) research. In addition, for any child category, if the IRB determines that a research study is designed for conditions or for a subject population for which parental or guardian permission is not a reasonable requirement to protect the subjects (for example, neglected or abused children), the IRB may document that the study meets the following criteria for a waiver of the parental permission requirements: an appropriate mechanism for protecting the children who will participate as subjects in the research is substituted, and the waiver is not inconsistent with federal, state, or local law. The choice of an appropriate mechanism would depend upon the nature and purpose of the activities described in the study, the risk and anticipated benefit to the research subjects, and their age, maturity, status, and condition.

9.3 Prisoners

9.3.1 Applicability of Prisoner Requirements

(Revised 6/29/17)

For research not eligible for equivalent protections (see Section 2.1.2), the requirements in Section 9.3 apply to all subjects meeting the definition of prisoner in Section 13. For research eligible for equivalent protections, these requirements apply to subjects who meet the definition of prisoner at the time of enrollment in the study.

Accordingly, there are different requirements in the situation where a subject already enrolled in a research study that was not approved for the inclusion of prisoners becomes incarcerated.

For research not eligible for equivalent protections, all study-related activities must cease until the continued participation of the subject has been approved by the IRB according to the requirements in Section 9.3, unless continuation of study interventions is in the best interest of the subject as in Section 6.6.2.1.5.2. The Principal Investigator must provide information to the IRB that will allow the IRB to determine whether the subject meets the definition of a prisoner and whether it is feasible for the subject to remain in the study and any risks associated with terminating participation in the study. If the subject's participation cannot be terminated for health or safety reasons, study-related activities may resume after the IRB has followed the procedures in this Section for review of the research. If the IRB determines that some the requirements cannot be met, but it is in the best interests of the subject to remain in the study, study activities may resume and the IRB will inform OHRP of the decision along with the justification. The IRB may consider the alternative of providing the subject with the study intervention through some other mechanism such as compassionate use or off label use, etc.

For research eligible for equivalent protections, the continued participation of the incarcerated subject may continue while the Principal Investigator provides information to the IRB that will allow the IRB to determine whether the subject meets the definition of a prisoner and whether it is feasible for the subject to remain in the study and any risks associated with terminating participation in the study. The IRB will review this information at the next available convened meeting, including review by a prisoner representative, and determine whether the subject should remain in the study.

9.3.2 Prisoner Representative Committee Members

(Revised 5/18/18)
At least one member of the IRB is a prisoner or prisoner representative who will participate in reviews of research involving prisoners. The prisoner representatives are registered with OHRP as prisoner representatives in accordance with the OHRP requirements. The prisoner representative counts towards quorum when research involving prisoners is reviewed. A majority of the IRB (exclusive of prisoner members) have no association with the prison involved, apart from their membership on the IRB.

9.3.3 Inclusion of Prisoners as Subjects

(Revised 2/24/17)
The Principal Investigator must clearly indicate in the IRB submission that subjects who are prisoners as defined in Section 13 will be enrolled and must describe the special protections for prisoners participating in research.

9.3.4 IRB Review of Research Involving Prisoners

(Revised 9/22/19)
A prisoner representative serves as one of the reviewers for any non-exempt study involving prisoners as subjects. A prisoner representative must be present at a convened meeting when research involving prisoners is reviewed. If the prisoner representative is not present, research involving prisoners cannot be reviewed or approved. The prisoner representative may attend the meeting by phone, video-conference, or webinar, as long as the representative is able to participate in the meeting as if they were present in person at the meeting. The prisoner representative must present their review either orally or in writing at the convened meeting of the IRB when the research involving prisoners is reviewed. Review of research involving interaction with prisoners must occur at a convened meeting for initial and continuing reviews, and for review of amendments that affect the involvement of prisoners. Review of non-exempt research that involves no interaction with prisoners, but uses their identifiable data, may occur by the expedited

procedure (which must include review by a prisoner representative at initial review and for review of amendments that affect the involvement of prisoners) if the research otherwise qualifies for expedited review (see Section 10.2.2).

The IRB makes a determination of the category under which the prisoner research is approved (see Section 9.3.6) and how the prisoner research satisfies each of the criteria listed in Section 9.3.5. Study-specific justifications that the research falls into a permissible category and meets each of the applicable criteria will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. The outcome letter will state the approval category for prisoner research. For research that is supported by the Department of Health and Human Services or other federal agencies that have adopted Subpart C, the IRB submits to OHRP:

- A certification letter indicating that the IRB has made the seven findings under Section 9.3.5, including identification of the permissible categories of research involving prisoners; and
- A copy of the research proposal reviewed by the IRB.

No non-exempt research activities involving prisoners may be started until approval has been obtained from the IRB.

9.3.5 Additional Duties of the IRB Where Prisoners Are Involved

(Revised 9/15/20)

The IRB will approve research involving prisoners if it finds that:

- The research under review represents one of the categories of research permissible under Section 9.3.6; and
- Any possible advantages accruing to the prisoner through their 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 their ability to weigh the risks of the research against the value of such advantages in the limited choice environment of the prison is impaired; and
- The risks involved in the research are commensurate with risks that would be accepted by nonprisoner volunteers; and
- 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; and
- The information is presented in language which is understandable to the subject population; and
- 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 their parole; and
- 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.

9.3.6 Permitted Research Involving Prisoners

(Revised 9/15/20)

Biomedical or behavioral research may involve prisoners as subjects only if the proposed research involves solely the following:

- 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. For prisoners, “minimal risk” means 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; or

- 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; or
- Research on conditions particularly affecting 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 of Health and Human Services has consulted with appropriate experts including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of their intent to approve such research; or
- 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 of Health and Human Services has consulted with appropriate experts, including experts in penology, medicine, and ethics, and published notice, in the Federal Register, of the intent to approve such research.

Epidemiological research may involve prisoners as subjects only if all three of the following criteria are met:

- The sole purposes of the research are either (i) to describe the prevalence or incidence of a disease by identifying all cases, or (ii) to study potential risk factor associations for a disease; and
- The research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects; and
- Prisoners are not a particular focus of the research.

9.4 Pregnant Persons, Fetuses, and Neonates

9.4.1 Applicability of Requirements for Pregnant Persons, Fetuses, and Neonates

(Revised 6/28/24)

For research funded or supported by a federal agency that applies subpart B of 45 CFR 46, the requirements in Sections 9.4.2, 9.4.3, 9.4.4, 9.4.5, and 9.4.6 apply to all research with pregnant persons, fetuses, and neonates as subjects. For all other research, these requirements apply if the research is greater than minimal risk to the pregnant person, fetus, or neonate. When the requirements apply, study-specific justifications that the research meets the applicable criteria will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. The outcome letter will state the approval category for pregnant persons, neonates, or placental/fetal materials.

Additional considerations in Section 9.4.7 based on the Commonwealth of Massachusetts Fetal Research Law: General Laws, Chapter 112, Section 12J, apply to all research on fetuses, whether or not the research constitutes research with human subjects.

The requirements in Section 9.4.8 for pregnancy information prior to an MRI performed solely for research purposes apply to all research enrolling persons of childbearing potential. The requirements in Section 9.4.9 for collecting information on pregnant partners apply to all research where the pregnant partners of research subjects are asked to authorize use and disclosure of their and their child's PHI.

9.4.2 Approval Criteria for Research Involving Pregnant Persons, Fetuses, or Neonates

(Revised 6/28/24)

Research involving pregnant persons, human fetuses, or neonates is reviewed according to the following criteria:

- Where scientifically appropriate, preclinical studies (including animal studies or non-pregnant women studies) have been conducted and provide data for assessing potential risks to pregnant persons and fetuses; and
- The risk to the fetus is caused solely by intervention or procedures that hold out prospect of direct benefit for the pregnant person or the fetus; or, if no such prospect of benefit, the risk to the fetus

must not be greater than minimal AND the purpose of the research is the development of important biomedical knowledge which cannot be obtained by any other means; and
- Any risk is the least possible for achieving the objectives of the research.

9.4.3 Informed Consent for Research Involving Pregnant Persons, Fetuses, or Neonates

(Revised 6/28/24)
The IRB will require consent from the pregnant parent for research that falls into one of the following categories:
- Research that holds out prospect of direct benefit for the **pregnant person or the fetus**; or
- Research that holds out prospect of direct benefit for **both the pregnant person and the fetus**; or
- Research that holds out no prospect of direct benefit to either the pregnant person or the fetus and the risk to the fetus is not greater than minimal and the purpose of the research is development of important biomedical knowledge that cannot be obtained by any other means.

The IRB will require consent from the non-gestational parent in addition to consent from the pregnant person for research that holds out the prospect of benefit solely to the fetus, if the research is funded or supported by a federal agency that applies subpart B of 45 CFR 46. For research not so funded or supported, the IRB may choose not to require consent from the non-gestational parent, based on the risks and benefits of the research. When the IRB determines that consent should be obtained from the non-gestational parent, such consent is not required if the non-gestational parent is unable to consent because they are not able to be contacted by phone, email, or mail; incompetent; or temporarily incapacitated; or if the pregnancy resulted from rape or incest.

For those minors who are pregnant and who meet the definition in Section 13 of children (those who have not attained the legal age for consent to treatments or procedures involved in the research), permission and assent is required as in Section 9.2. The IRB will determine whether a pregnant minor may consent for on their own behalf. Consideration is given as to whether the pregnant minor has been making their own clinical decisions (independent of parents or guardians).

Each individual providing consent must be fully informed regarding any reasonably foreseeable impact of the research on the fetus or neonate.

9.4.4 Other Requirements for Research Involving Pregnant Women, Fetuses, or Neonates

(Revised 6/28/24)
The following requirements apply to all research involving pregnant persons, human fetuses, or neonates:
- No inducements, monetary or otherwise may be offered to terminate the pregnancy; and
- Individuals engaged in research must have no part in any decisions as to the timing, method, or procedures used to terminate the pregnancy; and
- Individuals involved in the research must have no part in determining the viability of a neonate.

9.4.5 Approval Criteria for Research Involving Neonates of Uncertain Viability or Nonviable Neonates

(Revised 6/28/24)
Research involving neonates of uncertain viability and nonviable neonates is reviewed according to the following criteria:
- Where appropriate, preclinical studies (including animal studies or non-pregnant person studies) have been conducted and provide data for assessing potential risks for neonates; and
- The person providing consent is fully informed about reasonably foreseeable impact of research on the neonate; and
- Individuals engaged in research have no part in viability determination; and
- For research involving neonates of uncertain viability, the IRB must find that:
  - The research falls into one of the following two categories:

        - 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
        - The purpose of research is the development of important biomedical knowledge which cannot be obtained by other means and there is no added risk to the neonate resulting from the research; and
    - The legally effective informed consent is obtained from 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, except that the consent of the non-gestational parent or their legally authorized representative need not be obtained if the pregnancy resulted from rape or incest

For research involving nonviable neonates, the IRB must find that:

- Vital functions of the neonate are not artificially maintained; and
- The research will not terminate heartbeat or respiration of the neonate; and
- There will be no added risk to the neonate resulting from the research; and
- The purpose of the research is the development of important biomedical knowledge that cannot be obtained by other means; and
- The legally effective informed consent is obtained from both parents of the neonate. The only exceptions are if one parent is unavailable, incompetent, or temporarily incapacitated or if the pregnancy resulted from rape or incest. Waiver or alteration of consent under Section 8.4.3 is not permitted, nor is consent by the legally authorized representative of either or both parents under Section 9.5.

9.4.6 Research Involving the Placental or Fetal Material

(Revised 5/27/16)

Research involving, after delivery, the placenta, the dead fetus, or fetal material (macerated fetal material or cells, tissues, or organs excised from a dead fetus) must be conducted in accordance with any applicable federal, state, or local laws and regulations regarding such activities. If information associated with this material 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 the IRB must review this research according to the standards for human subjects research.

9.4.7 Research Using Fetuses or Fetal Tissue

(Revised 6/28/24)

The IRB will review submissions for research involving human fetuses and fetal tissue according to the Commonwealth of Massachusetts Fetal Research Law: General Laws, Chapter 112, Section 12J.

Live human fetuses. Research using a live human fetus before or after expulsion from its birthing parent's womb may only be approved by the IRB under Sections 9.4.2, 9.4.3, and 9.4.4 if the research is conducted for the purpose of developing, comparing or improving diagnostic or therapeutic fetal or neonatal interventions to improve the viability or quality of life of fetuses, neonates and children and if the procedures do not substantially jeopardize the life or health of the fetus or neonate and if the fetus is not the subject of a planned abortion.

Dead fetuses or neonates. Research using dead fetuses or neonates may only be approved by the IRB if the consent of the parent or guardian of the fetus or neonate has been obtained under Section 8.1.1. The IRB must also verify that no individual has performed or offered to perform the abortion providing the fetal material where part or all of the consideration for the abortion is that the fetal remains may be used for research.

The IRB will document in the electronic system that the research does not violate the provisions of subsection (a) of MGL 112 Section 12J, and file documentation with the office of the attorney general, including the outcome letter and the description of the research reviewed by the IRB.

9.4.8 Pregnancy Information Requirements for MRIs Done for Research Purposes

(Revised 6/28/24)
Although most studies do not show that non-contrast MRI scans cause harm to a fetus, there may be risks to a fetus that are not yet known. Therefore, pregnant persons should not get an MRI scan solely for research purposes unless justified by the study design. When a study involves one or more MRI scans done without a contrast agent solely for research purposes and scanning pregnant persons is not justified by the study design, all persons of childbearing potential (including adolescents) must be informed that the risks of MRI scans to a fetus are not known and that they should not undergo the MRI unless they are certain that they are not pregnant. For MRI scans done with a contrast agent solely for research purposes, the Principal Investigator must justify the risk of the contrast agent and describe additional protections, including pregnancy testing, if persons of childbearing potential are enrolled.

9.4.9 Pregnant Partners of Research Subjects

(Revised 6/28/24)
When a study involves collecting information about pregnant persons who are partners of research subjects, the pregnant partners are not considered to be human research subjects because they are not participating in the clinical investigation and the information is not being collected to develop or contribute to generalizable knowledge. However, the information about the pregnancy outcome to be obtained from the medical records of the pregnant partner and child constitutes PHI (see Section 13 for the definition of PHI), and so the pregnant partner must provide authorization for release of PHI to the researchers under HIPAA.

9.5 Decisionally-Impaired Persons

9.5.1 Additional Requirements for Decisionally-Impaired Persons

(Revised 5/30/17)
The use of decisionally-impaired persons as research subjects presents a risk that their disability may compromise their capacity to understand the information presented during the consent process and their ability to make a sound decision as to whether to participate in the research. For this reason, additional protections are required.

The Principal Investigator must indicate in the submission whether any subject who is cognitively impaired will be recruited, and if so, must describe how the subjects' ability to consent will be assessed, how Legally Authorized Representatives will be identified, and how the consent and assent process will prevent undue influence and coercion. When Legally Authorized Representatives are not English speakers and/or are limited- or non-readers, the additional consent requirements in Section 8.4.5 and/or Section 8.4.6, respectively, must also be followed. The Principal Investigator must explain why inclusion of decisionally-impaired subjects is necessary to answer the study question. If the study population is expected to include persons whose cognitive capacity may fluctuate during the course of the research, the Principal Investigator must describe plans for assessing cognitive capacity and obtaining consent from the subject to continue in the research when appropriate. In the case of subjects who are initially able to consent for themselves, it may be appropriate to ask them to identify a research-specific proxy to provide consent in the future.

The IRB will approve research on decisionally-impaired persons when:

- The consent/assent process adequately protects the rights and welfare of these subjects; and
- The Principal Investigator has adequately justified the inclusion of this vulnerable population as necessary to answer the study question, not merely as a convenience for recruitment; and
- The risks fall into one of the following categories:
  - No greater than minimal risk; or
  - Greater than minimal risk and the research holds out the prospect of direct benefit to the subjects; or

- Greater than minimal risk with no prospect of direct benefit to the subjects when BOTH of the following are true:
  - The knowledge likely to be gained through the research will improve the understanding of the condition, disease, or behavior affecting the participant population; and
  - The risks to subjects, including the risks of foregoing available alternative treatments, are not substantially greater than those associated with the available alternative approaches.

Study-specific justifications that the research meets the applicable criteria will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB.

9.5.2 Allowable Legally Authorized Representatives

(Revised 5/30/17)
A Legally Authorized Representative is an individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject's participation in the procedures(s) involved in the research, or recognized by institutional policy as acceptable for providing consent in the nonresearch context on behalf of the prospective subject to the subject's participation in the procedure(s) involved in the research. When the IRB approves for consent to be obtained from a subject's Legally Authorized Representative, an individual in the following categories will ordinarily be allowed for research conducted in Massachusetts (and the IRB will confer with counsel as needed for research conducted outside Massachusetts):

- Court appointed guardian (for any category of research involving decisionally-impaired persons): In some instances a court may have appointed a guardian who has authority to make decisions that include decisions to participate in research and undergo research procedures, on behalf of a subject who is decisionally impaired; or
- Research proxy (for any category of research involving decisionally-impaired persons): The subject may have designated a research proxy by durable power of attorney, health care proxy, or other legally valid document prior to the subject becoming decisionally impaired. The terms of the designation of a research proxy must specifically include making research decisions for the subject. A general durable power of attorney, healthcare proxy or "living will" does NOT automatically make someone eligible to make research decisions on behalf of a subject or serve as the research proxy; or
- General healthcare proxy (only for research involving decisionally-impaired persons that holds out the prospect of direct benefit to the subjects): The subject's general healthcare proxy may serve as the Legally Authorized Representative to consent for this type of research. The study records must clearly document how the healthcare proxy determination was made; or
- Next of kin (only for research involving decisionally-impaired persons that holds out the prospect of direct benefit to subjects or for minimal risk research where not obtaining the consent of the subject meets the waiver criteria in Section 8.4.3). The subject's next of kin may serve as the Legally Authorized Representative to consent for these types of research. The sequence of kinship is as follows: spouse, adult child, parent, adult sibling. When a potential subject has a spouse, the spouse is the next of kin. If the spouse is incapable of being the Legally Authorized Representative or is unavailable, the adult child may serve as the Legally Authorized Representative, and so on, down the line of kinship. The study records must clearly document how the next of kin determination was made. For minimal risk research where not obtaining the consent of the subject meets the waiver criteria in Section 8.4.3, the IRB does not make a formal waiver or alteration of consent determination, but includes a statement that the study meets the criteria in Section 8.4.3 as documented in the electronic system if the study is reviewed via the expedited procedure, or in the IRB minutes if the study is reviewed at an IRB meeting.

9.6 Students, Trainees, and Employees

(Revised 2/24/17)
The IRB aims to ensure that a subject's decision to participate in research is truly voluntary and that there is no coercion for persons to participate in research. Students, trainees (interns, residents, fellows, and postdoctoral scholars), and employees may be vulnerable to "subtle inducements to participate" in

research by such methods as promises of academic rewards, professional advancement, vacation time, etc. Therefore, the IRB requires that additional protections be in place in research studies where these persons will be targeted for recruitment.

Principal Investigators who intend to recruit students, trainees, or employees as subjects are required to clearly define the subjects to be enrolled, the rationale for their participation and the proposed method for their recruitment**.** Students, trainees, or employees should not be targeted for recruitment unless the research objective is to study this population. The appropriate official (see Section 7.2.2.2) is notified via the electronic system of the proposed targeting of students or trainees for recruitment and electronically signs off on the submission prior to approval by the IRB.

Students, trainees, and employees who directly report to the Principal Investigator or any of the co-investigators are generally not allowed to participate in their research studies. Such participation may be permitted for minimal risk research when the Principal Investigator has provided sufficient justification. Due to the increased risk of loss of confidentiality, the Principal Investigator must also explain in the submission the methods to be used to protect these subjects' identities in the research data.

9.7 Persons Revealing Potentially Damaging Information

9.7.1 Required Protections when Obtaining Potentially Damaging Information

(Revised 1/17/18)
All research information requires appropriate protection of confidentiality. A higher level of protection may be appropriate when disclosure outside the research context could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation. Examples of potentially damaging information include illegal conduct such as drug use and child abuse; stigmatizing conditions such as mental illness, contagious diseases, or HIV/AIDS; genetic predisposition to a disease; and potentially embarrassing opinions or practices.

When the research plan includes obtaining potentially damaging information from subjects, confidentiality protections must be appropriate.

9.7.2 Confidentiality Protections for Research Information

(Revised 8/11/19)
Confidentiality protections are required unless all research information is recorded in a way that there is less than a very small risk that subjects can be identified, even by investigators or research staff (that is, if the data are truly anonymous). Investigators must protect against both intentional and unintentional inappropriate releases of identifiable information and biospecimens. Physical protections against unintentional releases include storing information and biospecimens in locked, access-controlled locations. Electronic protections against unintentional releases include transmission and storage in password-protected, encrypted computer systems. Intentional releases of identifiable research information outside of the research context must be limited to releases for which the subject has given permission (including placement in the subject's medical record), to releases for which an IRB has waived permission, and to releases required by mandatory reporting (mandatory reporting applies to studies where the reportable information is intentionally collected and to studies conducted by mandated reporters in a setting where abuse or neglect is directly observable, such as a home, school, day care, or nursing home). Releases of information that has been stripped of identifiers are permitted, but subjects should be informed that such releases may occur and told that there is still a chance that someone could deduce their identity. The consent form templates found on the IRB website include appropriate language to communicate these confidentiality protections.

A Certificate of Confidentiality (CoC) provides protection against most compelled disclosure (e.g., by a subpoena or in connection with a legal proceeding) of identifiable information about research subjects. For studies funded by NIH and the Centers for Disease Control (CDC), the CoC is automatically granted. For studies not automatically granted a CoC, investigators must obtain a CoC if protections against

compelled disclosure are needed to minimize risks to subjects. If the IRB considers that a CoC is necessary to minimize risks to subjects, and the study is not automatically granted a CoC, a condition of IRB approval (see Section 10.3.2.2) will be obtaining a CoC.

In addition to the protections against most compelled disclosure, the CoC also prevents the researchers from disclosing any information to anyone not connected with the research except if disclosure is required or permitted by law (including when the subject has consented to disclosure or disclosure has been permitted by an IRB). All research studies that have a CoC must contain a description of the CoC in the consent form. The consent form templates found on the IRB website include appropriate language to communicate the CoC protections.

Information about CoCs can be found at https://humansubjects.nih.gov/coc/index and https://www.cdc.gov/od/science/integrity/confidentiality/applinst.htm The Principal Investigator can apply for a CoC for studies not automatically granted a CoC after conditional IRB approval with the only condition being obtaining a CoC. If the research is under FDA authority, the Principal Investigator should contact FDA for information on obtaining a CoC. If the research is health-related but not federally funded and not under FDA authority, the Principal Investigator should apply to the institute within the NIH whose health-related mission area most closely matches the subject matter of the research. If the research is funded by another Health and Human Services agency that has a CoC program (Health Resources and Service Administration and Substance Abuse and Mental Health Services Administration), the Principal Investigator should contact that agency for information on obtaining a CoC. Certain federal agencies outside of Health and Human Services maintain separate confidentiality certificate programs, such as the Agency for Healthcare Research and Quality and the Department of Justice.

All biomedical, behavioral, clinical or other research funded wholly or in part by any of the NIH Institutes (see list of NIH Institutes at https://www.nih.gov/institutes-nih/list-nih-institutes-centers-offices) that collects or uses identifiable, sensitive information is subject to the NIH Policy for Issuing Certificates of Confidentiality NOT-OD-17-109 (NIH CoC Policy). The CoC Policies for NIH and CDC are included as a standard term and condition of awards. A CoC will be deemed to be issued for research funded by NIH or CDC if the research gathers or uses identifiable, sensitive information when an individual is identified or there is at least a very small risk that some combination of the information, a request for the information, and other available data sources could be used to deduce the identity of an individual.

The NIH or CDC grantee who is deemed to be issued a CoC is required to protect the privacy of the individuals who are subjects of the research. The CoC Policy applies to all NIH or CDC Funded Research under any of the following circumstances:

- The research involves Human Subjects as defined by the Federal Policy for the Protection of Human Subjects; or
- The research collects or uses biospecimens that are identifiable to an individual as part of the research; or
- The research involves collection or use of biospecimens and there is a small risk that some combination of the biospecimen, and other available data sources could be used to deduce the identity of the individual; or
- The research involves the generation of individual level, human genomic data.

Investigators with CoCs issued by an agency other than NIH or CDC should obtain information from that agency on their specific obligations.

9.8 Targeted Homeless Individuals, Terminally Ill Individuals, and Individuals with Psychiatric Disorders

9.8.1 Targeted Homeless Individuals

(Revised 8/30/16)

Research that targets homeless individuals as a population to be recruited must include the following special protections:

- Inclusion of homeless individuals as subjects must be necessary to answer the study question, not merely a sample of convenience; and
- The type and amount of reimbursements or incentives must not present undue influence for homeless individuals to accept risks that non-homeless individuals would not accept; and
- When children are not included as subjects, appropriate procedures should be followed for verifying that a potential subject is 18 or older; and
- When children are included as subjects, appropriate provisions should be described for obtaining parent/legal guardian permission or an appropriate justification should be provided for waiving permission.

9.8.2 Targeted Terminally Ill Individuals

(Revised 2/24/17)
Research that targets terminally ill individuals as a population to be recruited must include the following special protections:

- The consent process should describe extra steps to ensure that:
  - Subjects and their family members understand that the project is research, not treatment; and
  - Family members do not pressure the potential subject into participating against the subject's wishes; and
- The consent form should include palliative care as an alternative; and
- If applicable, the consent process should ask permission for obtaining information after the subject's death.

9.8.3 Targeted Individuals with Psychiatric Disorders

(Revised 8/30/16)
Research that targets individuals with psychiatric disorders as a population to be recruited must include the following special protections:

- The plan for assessing cognitive capacity to consent/assent to initial and continued participation must follow the requirements in Section 9.5.1; and
- The plan for ensuring the subject's compliance with study safety measures must be appropriate to the degree of risk; and
- The plan for responding to suicide risk, if appropriate, must follow the requirements in Section 9.9.

9.9 Persons at Risk for Suicide

(Revised 2/24/17)
When information is likely to be obtained during research that indicates that an individual is at risk of self-harm, it is the responsibility of the researchers to have a safety protocol that describes how they will follow up in a timely and appropriate manner.

A study is required to have a suicide safety protocol when persons at risk for suicide are targeted by the research or when one or more of the questions asked of the subjects would reveal a suicide risk (for example, child and adult depression questionnaires typically include questions about suicide). A study is not required to have a suicide safety protocol when information indicating self-harm is not expected to be revealed; however, investigators and research staff are expected to respond appropriately if a subject reveals suicidal thoughts incidentally during research.

The suicide safety protocol must describe:

- How information about risk for suicide will be obtained and by whom; and
- If subjects do not provide this information directly to an investigator or research staff member (for example, by completing paper or electronic questionnaires), how much time elapses before the responses are reviewed; and
- Which investigator(s) or research staff will provide the expertise to assess and respond to suicide risk; and
- What actions will be taken in response to particular levels of revealed risk.

The consent process for studies with a suicide safety protocol must describe in the confidentiality section the measures that will be taken if a subject reveals a risk for suicide (see Section 8.2.3).

10 IRB Procedures for Conducting Review

10.1 Review Criteria

10.1.1 Evaluation of Submissions

10.1.1.1 Criteria for Approval

(Revised 8/11/19)

The IRB, through its review of initial submissions and its oversight of ongoing studies, protects the rights and welfare of human research subjects by ensuring that the following criteria are met. These criteria require that**:**

- The research design is scientifically appropriate and the degree of risk to the human subjects is justifiable. Studies that the IRB determines do not have a valid scientific purpose or that can be seen as an inducement to prescribe a specific drug or to use a specific device will not be approved; and
- Risks to subjects are minimized by using procedures that are consistent with sound research design and that do not unnecessarily expose subjects to risks, and whenever appropriate by using procedures already being performed on the subjects for diagnostic or treatment purposes; and
- The risks to subjects are reasonable in relation to anticipated benefits (if any) to subjects, the general public, and science, and the importance of the knowledge that may reasonably be expected to result. (In evaluating risks and benefits, the IRB will consider only those risks and benefits that may result from the research, as distinguished from risks and benefits of therapies subjects would receive even if not participating in the research.); and
    - Selection of subjects is equitable. In making this assessment the IRB takes into account the purposes of the research and the setting in which the research will be conducted. The IRB is particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons; and
- Legally effective informed consent will be obtained from each prospective research subject or the subject's legally authorized representative and will be documented in accordance with, and to the extent required by, Section 8.1.1; and
- When appropriate, the research plan makes adequate provision for monitoring of the data collected to ensure the safety of subjects; and
- There are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data; and
- Vulnerable populations are protected and that they are not being coerced, or otherwise taken advantage of. Vulnerable populations include those identified in Section 9, as well as any groups of vulnerable subjects identified through knowledge of local research context.

10.1.1.2 IRB Evaluation

10.1.1.2.1 Overall Evaluation

(Revised 7/25/16)

The IRB will approve a submission if it meets the criteria for approval in Section 10.1.1.1.

10.1.1.2.2 Identifying and Managing Risks

(Revised 2/24/17)

IRB members are equipped by their training and experience to recognize research risks. For a particular submission, risks, as well as the adequacy of resources to minimize risks, are identified based on the following descriptions in the submission:

- Identification of the Principal Investigator and research staff (Section 7.2.2.2); and
- Special features routed for sign off (Section 7.2.2.2); and
- Conflict of interest information (Section 7.2.2.5); and
- Recruitment information (Section 7.2.2.6); and
- Privacy protections (Section 7.2.2.7.1); and
- Confidentiality protections (Section 7.2.2.7.2); and
- Drug information (Section 7.2.2.8.1); and
- Device information (Section 7.2.2.8.2); and
- Risks (Section 7.2.2.9); and
- Subject characteristics (Section 7.2.2.10); and
- Consent procedures (Section 7.2.2.12); and
- Design/Procedures (Section 7.2.2.14); and
- Subject inclusion and exclusion criteria (Section 7.2.2.14.2); and
- Data Safety and Monitoring (Section 7.2.2.15); and
- Use of ionizing radiation (Section 7.2.2.16.5); and
- Multi-site research (Section 7.2.2.16.6); and
- Department Chair or Section Chief Signatures (Section 7.3.2).

The IRB identifies benefits based on the following descriptions in the submission:

- Drug information (Section 7.2.2.8.1); and
- Device information (Section 7.2.2.8.2); and
- Benefits (Section 7.2.2.9); and
- Purpose (Section 7.2.2.13); and
- Outcomes (Section 7.2.2.14.3); and
- Design/Procedures (Section 7.2.2.14).

Additional measures to minimize risks include the requirements for investigator and research staff training and education in performing human subjects research (see Section 6.2.3), for Principal Investigator qualifications (see Section 6.2.1), and for managing Conflicts of Interest (see Section 6.5).

The IRB will evaluate the proposed research to ensure that appropriate measures for minimizing risks to special populations as described in Section 9 are included.

The IRB will communicate to the Principal Investigator if any risks do not appear to have been minimized, asking either for changes to better minimize the risks or for an explanation of why the risks are in fact minimized.

The IRB will approve research only if risks have been minimized, and if any remaining risks are reasonable in relation to the potential benefits to subjects and/or society.

10.1.1.2.3 Evaluating Plans for Data Safety and Monitoring

(Revised 2/24/17)

The IRB will evaluate the plans proposed for Data Safety and Monitoring for greater than minimal risk studies (see Section 7.2.2.15) to determine whether:

- The individuals responsible for the internal monitoring of study activities have appropriate qualifications; and
- The written plan for the monitoring entities includes appropriate meeting and monitoring frequency, interim analyses, reporting, stopping rules, and definitions of Unanticipated Problems, Adverse Events, and Serious Adverse Events.

The Data Safety and Monitoring plan for minimal risk research consists of the Principal Investigator verifying that the reporting requirements in Section 6.6.3 will be followed, which is appropriate when risks are expected to be minimal.

The IRB will communicate to the Principal Investigator if the Data Safety and Monitoring plan does not appear to adequately protect subjects, asking either for changes in the plan or an explanation of why the plan does in fact protect subjects.

The IRB will approve research only if the Data Safety Monitoring plan appropriately minimizes risks.

10.1.1.2.4 Evaluating Plans for Selection of Subjects

10.1.1.2.4.1 Appropriateness of Recruitment Methods

(Revised 8/11/19)
The IRB will evaluate the plans proposed for selecting and recruiting subjects based on the following information from the submission:

- Recruitment information (Section 7.2.2.6); and
- Subjects (Section 7.2.2.10); and
- Costs and Payment (Section 7.2.2.11); and
- Consent Information (Section 7.2.2.12); and
- Inclusion and Exclusion Criteria (Section 7.2.2.14.2).

The recruitment process will be considered fair and appropriate if the privacy and confidentiality of potential subjects is protected, the recruitment materials are accurate, any costs of the research are not expected to unfairly exclude potential subjects, any payments constitute a reasonable reimbursement for time and effort and are not so large as to constitute undue influence to participate, and the consent process will convey information needed for potential subjects to consider whether or not to participate.

The IRB will communicate to the Principal Investigator if the recruitment plan does not appear to be fair and appropriate based on the above criteria, asking either for changes in the recruitment plan or an explanation of why the recruitment plan is in fact fair and appropriate.

The IRB will approve research only if the recruitment plan appropriately minimizes risks.

10.1.1.2.4.2 Equitable Selection of Subjects

(Revised 8/11/19)
The IRB will use the information about recruitment of the subject population (see Section 10.1.1.2.4.1) in conjunction with the information about risks and benefits (see Section 10.1.1.2.2) to determine whether the selection of subjects is equitable, that is, whether the population from which the subjects will be drawn, therefore the population that will experience any risks of the study, is the same as the population that is expected to benefit from the results of the study. In making this assessment the IRB takes into account the purposes of the research and the setting in which the research will be conducted. The IRB is particularly cognizant of the special problems of research that involves a category of subjects who are vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons.

The IRB will communicate to the Principal Investigator if the selection of subjects does not appear to be equitable, asking either for changes in the study or an explanation of why the selection of subjects is in fact equitable.

The IRB will approve research only if the selection of subjects is equitable.

10.1.1.2.5 Evaluating Plans for Protection of Privacy

(Revised 2/24/17)
The IRB will evaluate the plans proposed for protecting subject privacy based on the following information from the submission:

- Recruitment information (Section 7.2.2.6); and
- Privacy Protections Information (Section 7.2.2.7.1); and
- Experimental Design Information (Section 7.2.2.14.1); and
- Documents Used to Obtain Information from Subjects (Section 7.2.2.14.6).

If the Principal Investigator states that the information to be obtained from and about subjects and potential subjects is the minimum necessary to conduct the study and that interventions and interactions with subjects and potential subjects will take place in private settings, the IRB will evaluate the information to be obtained to verify that the privacy interests of the subjects are appropriately protected. If the Principal Investigator describes other measures that will be used to protect the privacy of subjects and potential subjects, the IRB will evaluate whether these measures are appropriate.

The IRB will communicate to the Principal Investigator if the provisions for protection of privacy do not appear to be appropriate, asking either for changes in the study or an explanation of why the provisions are in fact appropriate.

The IRB will approve research only if the provisions to protect the privacy of subjects are adequate.

10.1.1.2.6 Evaluating Plans for Maintaining Confidentiality

(Revised 1/17/18)
The IRB will evaluate the plans proposed for maintaining confidentiality based on the following information from the submission:

- HIPAA Compliance (see Section 7.2.2.3); and
- Confidentiality Protections Information (Section 7.2.2.7.2); and
- Design/Procedure Information (Section 7.2.2.14).

The IRB will evaluate the sensitivity of the identifiable information to be collected, based on whether the disclosure of the information outside the research setting could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation. The more sensitive the identifiable information, the greater the required protections. Specific considerations and requirements for research for which NIH or another institution has granted a CoC or that may otherwise require a CoC are described in Section 9.7.2.

The IRB will communicate to the Principal Investigator if the provisions for protection of confidentiality do not appear to be appropriate for the sensitivity of the identifiable information collected, asking either for changes in the confidentiality protections or an explanation of why the protections are in fact appropriate.

The IRB will approve research only if the provisions to maintain the confidentiality of data are adequate.

10.1.1.2.7 Evaluating Plans for Obtaining Consent

(Revised 6/23/19)
The IRB will evaluate the plans for obtaining consent based on the following information from the submission:

- Recruitment information (Section 7.2.2.6); and
- Privacy and confidentiality protections (Section 7.2.2.7); and
- Subjects (Section 7.2.2.10); and
- Costs and Payment (Section 7.2.2.11); and
- Consent Information (Section 7.2.2.12), including the consent forms (Section 7.2.2.12.7); and
- Design/Procedure Information (Section 7.2.2.14).

The IRB will evaluate whether the proposed process and forms comply with the requirements in Sections 8.1.3 and 8.2 and will enable prospective subjects to understand the consequences of enrolling in the study, including sufficient time to consider enrolling, information conveyed in clear and unbiased language, the opportunity to get answers to questions, and an adequate process to verify subject understanding prior to consent. If there is no consent process or there is an alteration of any of the required elements of consent, the IRB will evaluate whether the research qualifies for a waiver or alteration according to Section 8.4.3 or 8.4.4.

The IRB will evaluate whether the documentation of the consent process complies either with the requirements in Section 8.4.1 or qualifies for a waiver of documentation of consent according to Section 8.4.2.

The IRB will communicate to the Principal Investigator if the consent process, including consent forms, does not appear to be appropriate, asking either for changes in the consent process or an explanation of why the process is in fact appropriate.

The IRB will approve research only if legally effective informed consent will be obtained from each prospective research subject or the subject's legally authorized representative or if the research qualifies for a waiver or alteration of consent, and, if informed consent is obtained, the consent will be documented unless the research qualifies for a waiver of written documentation of consent. When consent is altered or waived and when written documentation of consent is waived, the study-specific justifications will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB.

10.1.1.2.8 Evaluating Protections for Special Populations

(Revised 5/30/17)
The IRB will evaluate the plans for protection of special populations based on the following information from the submission:

- Subjects (Section 7.2.2.10); and
- Consent Information (Section 7.2.2.12)

The IRB will evaluate risks of the research according to Section 10.1.1.2.2 to determine whether risks are minimized for all special populations and whether the protections for all identified special populations comply with the applicable requirements in Section 9.

The IRB will communicate to the Principal Investigator if the protections for special populations do not appear to be adequate, asking either for additional protections or an explanation of why the protections are in fact adequate.

The IRB will approve research only if additional safeguards have been included in the study to protect the rights and welfare of special populations of subjects. Study-specific justifications will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB for determinations under Sections 9.2, 9.3, 9.4, and 9.5.

10.1.1.2.9 Evaluating Plans for Managing Conflicts

(Revised 10/27/21)
If the Boston Medical Center and Boston University Medical Campus IRB reviews the research, the Boston Medical Center and Boston University Medical Campus IRB will review management plans for Financial Conflicts of Interest established by the Boston Medical Center/Boston University Faculty Review Committee on Research Financial Conflicts of Interest and accepted by the conflicted individual as described in Section 6.5. The IRB may require alterations in the management plan to impose additional or more restrictive requirements, which must be accepted by the conflicted individual. The IRB will assess intellectual property interests disclosed as described in Sections 7.2.2.8.1 and 7.2.2.8.2 to determine whether a management plan for intellectual property interest is warranted. Management plans can include specifying the information that will be disclosed to subjects; limiting the involvement of individuals with

conflicts in study activities such as recruitment, obtaining consent, and study analysis; and requiring independent monitoring.

Management plans for studies not ceded to a reviewing IRB will be reviewed and approved at a convened meeting by a separate vote. The IRB will vote to approve the management plan for research where a financial or intellectual property conflict of interest exists only if the conflicts are managed in a way that preserves the rights and welfare of the subjects and the integrity of the data.

10.1.2 Review of Progress Reports for Continuing Review of Approved Studies

(Revised 5/26/26)
Continuing review starts with the working presumption that the research, as previously approved, does satisfy all of the criteria in Section 10.1.1.1. The review will focus on whether there is any relevant new information (provided by the Principal Investigator from external sources, based on the reported experience in the study, or otherwise available to the IRB), that would alter the prior determinations, particularly with respect to the prior evaluation of the potential benefits or risks to the subjects.

When conducting continuing review and evaluating whether research continues to satisfy the criteria for approval in Section 10.1.1.1, the review will pay particular attention to the following four aspects of the research:

- Risk assessment and monitoring; and
- Adequacy of the process for obtaining informed consent, including whether the current consent documents are accurate and complete; and
- Investigator and institutional issues; and
- Research progress.

The review will also evaluate:

- The submitted analysis of the pattern of Adverse Events, including Serious Adverse Events, to assess whether in total, this pattern suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm), based on their nature or frequency of occurrence, than was known at the time of previous approval; and
- The summary of minor deviations to assess whether, taken together, they indicate a risk of harm to subjects or others, or if they indicate the possibility of continuing noncompliance; and
- Any information that verification is needed from sources other than the investigators that no material changes have occurred since previous IRB review (see Section 10.4.2); and
- Whether any significant new findings that arise from the review process and that might relate to subjects' willingness to continue participation will be provided to subjects.

If the Progress Report indicates that the short form consent process has been used three or more times for the same language, or that the short form has been used in a greater than minimal risk study without confirmation that a full translation has been obtained, the Principal Investigator will be contacted and asked to submit an amendment providing a full translation of the consent form in the relevant language(s), unless the IRB has previously determined that continued use of the short form is appropriate (see Section 8.4.5.2).

Progress Reports will be approved if the research continues to satisfy the criteria for approval in Section 10.1.1.1. Progress Reports where the remaining research activities are limited to data analysis will be approved if the Principal Investigator indicates that interventions and follow-up are complete, that analysis of identifiable information is still in progress, and that no problems have been identified. A Progress Report will not be approved as submitted if the Progress Report contains relevant new information about risks or benefits, suggests a greater risk of harm to subjects or others, or indicates the possibility of serious or continuing noncompliance. If such a Progress Report is initially reviewed by an Expediter, the Expediter will refer the Progress Report to a convened IRB meeting. The convened IRB will determine the appropriate actions, including obtaining more information from the Principal Investigator, requiring the Principal Investigator to make changes, scheduling a targeted audit (see Section 11.3.4), and suspending or terminating approval for the study (see Section 11.5).

10.2 Types of Review Processes

10.2.1 Convened IRB Review

10.2.1.1 Materials Provided to IRB Members

(Revised 12/05/25)
No later than 5 days before a board meeting, all board members scheduled for the meeting will receive the agenda. The IRB Director limits the number of items on the agenda to allow for adequate time for discussion.

The agenda lists the following:

- Announcements (if any); and
- Educational material (if any); and
- Minutes of previous meeting(s) that require review by the convened IRB (if any); and
- Audit Reports (if any); and
- Submissions to be reviewed at the meeting, including:
  - Study number and title; and
  - Principal Investigator; and
  - Primary and secondary reviewers; and
- Expedited actions performed on behalf of the panel since the previous agenda was distributed.

Members have access through the electronic system to all study information for the submissions as described in Section 7.2.2. Primary reviewers (and secondary reviewers for initial submissions) conduct in-depth review of all pertinent documentation as appropriate for the study.

Additional materials pertaining to items already on the agenda may be distributed prior to the meeting if appropriate. The IRB Director, with the agreement of the panel Chair, may allow the addition of a new agenda item with materials sent fewer than 5 days prior to a meeting if there is a need for a rapid review. In such cases, the members will be asked to abstain if they have not had sufficient time to review the materials.

10.2.1.2 Convened IRB Reviews of Initial Submissions

(Revised 2/24/17)
The IRB staff assign a primary and secondary reviewer for each new study that will be reviewed by the convened IRB. The IRB Chair or the IRB Director may assist with the assignment of reviewers. The assignment is based upon expertise or familiarity with the topic of the research or the study populations as much as possible. If no panel member has the necessary scientific expertise, the IRB Director will arrange for a consultant (see Section 3.8) to provide a scientific review. For studies meeting the definition of a clinical trial in Section 13 and that are initiated by the Principal Investigator, the IRB Director will determine whether or not the research has undergone peer review (for example, by an NIH study section), and if not, will arrange for review by a biostatistician. The biostatistical review may be presented by the biostatistician at the convened meeting or may be made available to all members through the electronic system. The primary and secondary reviewers serve as the lead discussants and present a summary of the study to the panel for discussion and vote during the convened meeting.

10.2.1.3 Convened IRB Reviews of Amendments

(Revised 9/25/18)
For amendments reviewed by the convened IRB, a primary reviewer system is used. The primary reviewer serves as the lead discussant and presents a summary of the amendment information to the panel for discussion and vote during the convened meeting.

The vote will include whether or not revised consent form(s) or consent addendum(s) are approved, and if so, whether and how, in addition to newly-recruited subjects, the revised forms must be used for any groups of already-consented subjects, such as subjects currently receiving study interventions, active subjects who will experience the change, or all subjects. Subjects should be re-consented if the changes could affect their willingness to continue to participate in the study or could appreciably affect their experience in the study. The decision to require re-consent will consider the burden on the subjects and the study team in relation to the potential importance of the new information to the subjects' decision to remain in the study.

Examples of the types of changes that could lead the convened IRB to determine that already-consented subjects need to be re-consented include, but are not limited to:

- New findings that negatively affect the risk/benefit profile of the study (such as the identification of new risks, an increase in the magnitude of known or suspected risks, or a decrease in the expected benefit); and
- Changes in privacy and confidentiality protections (such as new plans for sharing study information); and
- The addition, modification, or removal of study procedures; and
- Changes to costs or reimbursement that are substantive enough to meaningfully affect a subject's decision about whether to remain in the study; and
- The identification of new alternative treatments.

Examples of types of changes that could lead the convened IRB to determine that already-consented subjects do not need to be re-consented, include, but are not limited to:

- A minor increase in reimbursement; and
- The removal of a questionnaire from future study visits; and
- The addition of a specific new chart review variable if it is not sensitive and if it fits within a broader category (such as medical history) that is already explained to subjects in the consent form.

These consent determinations will be included in the minutes and in the outcome letter to the Principal Investigator.

10.2.1.4 Convened IRB Reviews of Progress Reports for Continuing Reviews

(Revised 2/24/17)
Continuing reviews by the convened IRB are conducted according to Section 10.1.2, and a primary reviewer system is used. The primary reviewer serves as the lead discussant and presents a summary of the renewal information to the panel for discussion and vote during a convened meeting.

10.2.1.5 Convened IRB Review of Reportable Events and New Information

(Revised 9/16/26)
Reports of Unanticipated Problems, major deviations, and safety monitors' reports with required changes or recommended changes involving subject safety are reviewed by the IRB Director or designee within 2 calendar days of submission to the IRB if the report is for an Unanticipated Problem associated with a fatal or life-threatening incident or within 7 calendar days of submission to the IRB otherwise. If urgent action is required, the Chair and/or Vice Chair of the responsible panel will be contacted for review and approval of appropriate corrective actions. Any such actions approved by the Chair or Vice Chair will be reported to the responsible panel at the next convened meeting. If less-urgent action is required, the report and the accompanying amendment request will be scheduled for review at a convened meeting of the responsible panel. If the reported event or incident does not constitute an Unanticipated Problem, major deviation, or safety monitors' report with required changes or recommended changes involving subject safety, the submission will be processed by the IRB Director or designee according to whether acknowledgement under Section 10.3.2.5 or other communication with the Principal Investigator is warranted. Reports of major deviations will be assessed as described in Section 11.4.3 and will be evaluated by the convened IRB if the deviation might constitute serious or continuing noncompliance (see

Section 11.4.2). The determinations of the convened IRB concerning Reportable Events and New Information will be recorded in the minutes.

The IRB Director or designee will confirm with the IBC Compliance Specialist that the IBC has been informed of any Unanticipated Problem reports for studies involving the use of gene transfer.

Each report confirmed by the IRB to meet the definition of an Unanticipated Problem or serious or continuing noncompliance is reported as described in Section 10.7.

10.2.1.6 Convened IRB Review vs. Expedited Review of Research Involving Repositories or Retention of Samples or Data

(Revised 6/01/21)
For research with the sole purpose of establishing a repository (see Section 13), the IRB Director will determine whether initial review should be conducted by the convened IRB because of particular risks or unique issues. In that instance, if the IRB board determines that the research is no greater than minimal risk, continuing reviews may be conducted by the expedited procedure.

For research involving the retention of samples or data for extra use, the IRB Director may determine that a particular study that otherwise qualifies for exemption (see Section 10.2.4.2.2) requires expedited review or review by the convened IRB based on the nature and complexity of the retention activities or due to particular risks or unique issues with the data or samples.

10.2.1.7 Executive Board Reviews

(Revised 8/11/19)
The Executive Board is responsible for reviewing and approving materials that would be used across a number of studies. Submissions appropriate for consideration by the Executive Board include consent form templates, informational brochures, and standard psychological instruments, as well as materials receiving conflicting determinations at two different panels. The Executive Board will review noncompliance reports referred to the Executive Board by a panel, the HRPP Director, or one of the IOs. The Executive Board makes determinations following HRPP policies. Panels may require changes to materials approved by the Executive Board, in which case, the panel minutes will record the reason for the changes. The Executive Board does not routinely review initial submissions, amendments, continuing reviews, or Reportable Events and New Information submissions.

10.2.2 Review by the Expedited Procedure

10.2.2.1 Expedited Reviewers (Expediters)

(Revised 8/11/19)
Under an expedited review procedure, the review of initial submissions, amendments, progress reports, status check-in reports, and Reportable Events and New Information submissions may be carried out by an IRB Chair or by an experienced reviewer designated by the Chair from among members of the Chair's panel as an Expediter. An IRB member will be considered "experienced" for the purpose of being designated an Expediter based on prior service as an IRB member, knowledge, training, performance of reviews under the mentorship of an Expediter, and participation in IRB meetings. Both full and alternate members may be considered "experienced." The IRB Director will communicate with the Chair of an IRB member's panel concerning recommendations that the member be designated as an Expediter. Expediters receive additional training concerning the expedited review categories and the expedited review procedure in the electronic system.

10.2.2.2 Authority of the Expediter

(Revised 2/24/17)
Expediters exercise full IRB authority except they may not disapprove submissions. The expedited review procedure is not used to circumvent the normal review process. Expediters may obtain assistance with

their reviews from the IRB Director, Chairs, or other IRB members, and may refer a submission for convened IRB review if additional expertise or ethical consideration is deemed appropriate.

10.2.2.3 Keeping Members Advised of Research Proposals Which Have Been Approved Under the Expedited Procedure

(Revised 2/24/17)
The IRB agenda is used to inform IRB members of research that was approved by the expedited review procedure as described in Section 10.2.1.1.

10.2.2.4 Eligibility for Expedited Review

10.2.2.4.1 Expedited Review of Initial Submissions

10.2.2.4.1.1 Eligibility of Initial Submissions for Expedited Review

(Revised 1/17/18)
Initial submissions are eligible for an expedited review if (1) they involve no more than minimal risk and (2) the only involvement of human subjects is in one or more of the expedited categories in Section 10.2.2.4.1.2, the expedited categories in Section 10.2.2.4.1.3 for research eligible for equivalent protections, or in exempt categories 2(iii) or 3(i)(C) in Section 10.2.4.2.1.2.

The consideration of whether a study is minimal risk will include evaluating the adequacy of the protections against invasion of privacy and breach of confidentiality where identification of the subjects and/or their responses would reasonably place them at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, insurability, reputation, or be stigmatizing.

10.2.2.4.1.2 Common Rule Expedited Categories

(Revised 2/24/17)
Expedited review categories under the Common Rule are:

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 (21 CFR Part 312) 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 (21 CFR Part 812) 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 healthy, 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 per 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. Where 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. 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. This listing refers only to research that is not exempt.)

10.2.2.4.1.3 Equivalent Protections Expedited Categories for Initial Review

(Revised 5/30/17)

For studies eligible for equivalent protections (see Section 2.1.2), if the research is no greater than minimal risk and if the only involvement of human subjects will be in one or more of the following equivalent protections categories, the research is eligible for expedited review.

10. Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture, or indwelling catheter already in place for clinical purposes as follows:
    a. from nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period; 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 per kg in an 8 week period.
11. Prospective collection of biological specimens for research purposes by minimally invasive means.
    Examples: (a) tissues from nonfacial, nongenital skin punch biopsies in adults that do not require sutures; (b) collection of additional data and biological specimens during procedures already being performed for clinical purposes, such as additional biopsies during gastro-intestinal endoscopy, additional cerebrospinal fluid during lumbar puncture, or additional bone marrow during aspiration, without undue prolongation of anesthesia, sedation, or operating room time.
12. Collection of data in adults involving a single exposure to ionizing radiation with an effective dose not exceeding 0.1 mSv (the amount typically associated with a chest xray) provided appropriate shielding techniques are employed.

10.2.2.4.2 Expedited Review of Amendments

10.2.2.4.2.1 Expedited Review of Amendments to Approved Studies

(Revised 10/22/18)

Amendments are eligible for expedited review if the only involvement of human subjects is in one or more of the expedited categories in Section 10.2.2.4.1.2, the expedited categories in Section 10.2.2.4.1.3 for research eligible for equivalent protections, exempt categories 2(iii) or 3(i)(C) in Section 10.2.4.2.1.2, or if the requested amendments represent minor changes in previously approved research during the period for which approval was authorized by the convened IRB. Minor changes are changes that neither materially increase risk, nor materially decrease benefit, nor materially decrease scientific merit. Addition of an investigative site to a multi-site research study may be considered a minor change that may be reviewed by the expedited process when the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record (see Section 10.2.3.2).

The Expediter will specify whether or not revised consent form(s) or consent addendum(s) are approved, and if so, whether and how, in addition to newly-recruited subjects, the revised forms must be used for any groups of already-consented subjects, such as subjects currently receiving study interventions, active subjects who will experience the change, or all subjects. Subjects should be re-consented if the changes could affect their willingness to continue to participate in the study or could appreciably affect their experience in the study. The decision to require re-consent will consider the burden on the subjects and the study team in relation to the potential importance of the new information to the subjects' decision to remain in the study.

Examples of the types of changes that could lead the Expediter to determine that already-consented subjects need to be re-consented include, but are not limited to:

- Changes in privacy and confidentiality protections (such as new plans for sharing study information); and
- The addition, modification, or removal of study procedures; and
- Changes to costs or reimbursement that are substantive enough to meaningfully affect a subject's decision about whether to remain in the study; and
- The identification of new alternative treatments.

Examples of types of changes that could lead the Expediter to determine that already-consented subjects do not need to be re-consented, include, but are not limited to:

- A minor increase in reimbursement; and
- The removal of a questionnaire from future study visits; and
- The addition of a specific new chart review variable if it is not sensitive and if it fits within a broader category (such as medical history) that is already explained to subjects in the consent form.

These consent determinations will be included in the outcome letter to the Principal Investigator.

10.2.2.4.2.2 Review of Protocol Exceptions by the Chair or Vice Chair

(Revised 2/24/17)
Protocol exceptions, submitted with the information described in Section 6.6.4.3, are reviewed by the Chair or Vice Chair of the assigned panel. The Chair or Vice Chair may approve the exception if:

- The risks to the subject of the planned exception are no greater than minimal; or
- The exception provides the prospect of direct benefit to the subject; or
- The risks to the subject are reasonable in relation to the importance of the knowledge that may reasonably be expected to result from the inclusion of the subject.

The Chair or Vice Chair may ask the Principal Investigator for additional information, request an outside consultation, or refer the exception to the next convened panel meeting if the Chair or Vice Chair is not able to approve the exception request.

10.2.2.4.3 Expedited Review of Progress Reports and Status Check-In Reports

10.2.2.4.3.1 Expedited Review of Progress Reports for Research Approved with an Expiration Date

(Revised 6/20/18)
Progress Reports for research approved with an expiration date are eligible for expedited review if the only involvement of human subjects is in one or more of the expedited categories in Section 10.2.2.4.1.2 or in Section 10.2.2.4.1.3 for research eligible for equivalent protections, or if the submission represents continuing review of a project in the following additional expedited categories:

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 (note that studies in this category will generally be eligible for no expiration date if they comply with the requirements applicable on or after January 21, 2019).
9. Continuing review of research, not conducted under an investigational new drug application or investigational device exemption where categories two (2) through eight (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.

The Expediter conducts a continuing review according to Section 10.1.2, and receives and reviews the full submission including any changes previously approved by the IRB, informed consent form, and the Progress Report (which includes the study status; enrollment information; monitoring and auditing results; a summary of adverse events and minor deviations; subject complaints, withdrawals, and terminations; funding status; and identification of new risks since the last review).

10.2.3 Evaluation of Multi-Site Research

10.2.3.1 Evaluation of Requests to Cede Review

10.2.3.1.1 Evaluation of Initial Requests to Cede Review

(Revised 12/22/25)
A submission that requests that the Boston Medical Center and Boston University Medical Campus IRB rely on another IRB (see Section 7.2.2.18) is evaluated by the IRB Director or HRPP Director

The IRB Director or HRPP Director is responsible for assessing the quality of the proposed IRB of record. For research that is greater than minimal risk, the proposed IRB of record must be AAHRPP-accredited or in the process of obtaining AAHRPP accreditation. For research that is no greater than minimal risk, if the proposed IRB of record participates in SMART IRB (see Section 2.5.1), this will be considered sufficient evidence of quality, because participation in SMART IRB requires being AAHRPP accredited, being in the process of obtaining accreditation, or having undergone an OHRP Quality Assessment Program within the past 5 years. If the proposed IRB of record does not participate in SMART IRB, the IRB Director or HRPP Director will contact the proposed IRB of record to ask for access to their policies on how they conduct review of external sites (including provisions for local context review) and any letters or findings within the past five years from OHRP or FDA as a result of investigations or inspections of the IRB.

The IRB Analyst/Administrator will evaluate the information provided in the submission for accuracy and will contact the Principal Investigator if any clarifications or corrections are required. The specific information that will be evaluated is:

- Study type. If the request is to rely on a commercial IRB, the study must either be an industry-sponsored, multi-site trial involving an IND or IDE held by the industry-sponsor or a federally-supported multi-center trial where the commercial IRB has been selected as the IRB of record. The commercial IRB must be Hummingbird IRB (note that no new studies are ceded to Hummingbird IRB on or after September 1, 2019) or an AAHRP-accredited IRB that has indicated a willingness to execute the reliance agreement using the SMART IRB reliance agreement. For industry-sponsored, multi-site trials involving an IND or IDE held by the industry-sponsor, the billing arrangement must be set up so that the commercial IRB bills the sponsor directly for the IRB review costs; and

- The status of the training of all Boston Medical Center and Boston University Medical Campus study personnel, including the Principal Investigator (see Section 6.2.3); and
- Basic information, including clinical trial, funding, and special routing information (see Section 7.2.2.2); and
- Conflict of Interest information (see Section 7.2.2.5); and
- Details about recruitment procedures (see Section 7.2.2.18); and
- Details about sharing data with a third-party vendor or software application or program; and
- Compliance with local policies for who must be involved in the consent discussion (see Section 8.1.3.7); and
- Compliance with Massachusetts law regarding disclosure of HIV testing status; and
- Compliance with local policies for enrollment of:
    - Decisionally-impaired subjects who require the use of Legally Authorized Representatives (see Section 9.5); and
    - Subjects with limited English proficiency (see Section 8.4.5); and
    - Wards of the State (see Section 9.2.3); and
    - Limited- and non-readers (see Section 8.4.6); and
    - Students, trainees, and employees (see Section 9.6); and
    - Patients of specialty substance use disorder clinics or providers (see Section 7.2.2.10).

The IRB Director or HRPP Director will evaluate the submission to assess whether it is appropriate given the local context for the conduct of research at Boston Medical Center and Boston University Medical Campus. In order to fulfill this evaluation, the IRB Director or HRPP Director may require an evaluation of the submission by an IRB Chair or Vice Chair, board member, non-member consultant (see Section 3.8), or the applicable Institutional Official. The IRB Director or HRPP Director will ultimately determine as follows:

- Recommend that no changes are needed to proceed with relying on another IRB; or
- Recommend that one or both of the following types of changes are needed:
    - The local Principal Investigator should be asked for changes or clarifications to local procedures or the local sections of recruitment or consent documents; and/or
    - The IRB of record should be asked for changes or clarifications to study-wide procedures or documents which are necessary for the performance of the research at Boston Medical Center and Boston University Medical Campus; or
- Recommend that the study be reviewed by the Boston Medical Center and Boston University Medical Campus IRB.

The IRB Director or HRPP Director will take into account their own assessment of the quality of the proposed IRB of record and the evaluations from the IRB Analyst/Administrator and expert reviewer, if applicable, in deciding whether to proceed with relying on another IRB. The reliance agreement must satisfy the requirements of Section 2.5.3, including a description of how responsibilities are divided between the two organizations.

An Expediter, who may be the IRB Analyst/Administrator, the Chair, the IRB Director, or the HRPP Director, will evaluate requests for waivers or alterations of HIPAA authorization according to Section 8.5.2.2.

If the request to rely on another IRB (cede) is granted, an outcome letter is provided via the electronic system.

The cede letter includes the following information:

- Study name (with version number and/or date); and
- Notice of IRB delegation of review; and
- Review type; and
- Date of action; and
- Status check-in due date; and
- Use of PHI; and

- Funding source; and
- Designation of the IRB of Record; and
- Reminders of:
  - Requirements to submit communications to the IRB of Record; and
  - Requirements to submit to the Boston Medical Center and Boston University Medical Campus IRB the following: Changes made to eliminate an apparent immediate hazard to local subjects, Internal Study Personnel changes, serious and/or continuing noncompliance determinations and Unanticipated Problem determinations related to the conduct of the study at Boston Medical Center or Boston University Medical Campus, and changes to study procedures that appreciably alter compliance with Boston Medical Center and Boston University Medical Campus HRPP policies; and
  - Requirement to submit a Final Report in INSPIR when the IRB of record closes the study; and
  - Principal Investigator responsibilities.

10.2.3.1.2 Evaluation of Amendments for Ceded Studies

(Revised 3/2/25)
Requests to change study personnel for ceded studies will be evaluated according to Section 10.2.7.1. Other amendment requests for ceded studies will be evaluated to determine which changes require re-evaluation according to Section 10.2.3.1.1.

For studies ceded to an external IRB, changes to the research plan must be submitted as an amendment via the electronic system (see Section 7.4.1.2) if the changes:

- Affect compliance with local policies or seek to modify previously-granted policy exception requests for enrollment of:
  - Decisionally-impaired subjects who require the use of Legally Authorized Representatives (see Section 9.5); and
  - Subjects with limited English proficiency (see Section 8.4.5); and
  - Wards of the State (see Section 9.2.3); and
  - Limited- and non-readers (see Section 8.4.6); and
  - Students, trainees, and employees (see Section 9.6) and
  - Patients of specialty substance use disorder clinics or providers (see Section 7.2.2.10); or
- Affect compliance with local policies or seek to modify previously-granted policy exception requests for individuals involved the consent discussion for studies involving drugs, devices, or surgical procedures; or
- Affect information provided regarding the plan to prevent disclosure of HIV testing status to any non-Boston Medical Center research staff prior to written consent being obtained; or
- Affect information provided regarding the plan to share data with a third-party vendor or software application or program; or
- Affect information provided regarding recruitment procedures; or
- Add new or modify existing recruitment materials; or
- Affect information provided for a waiver of authorization for use and disclosure of Protected Health Information (see Section 8.5.2.2); or
- Require review by a special routing individual or entity that was not involved during the initial review process (see Section 7.2.2.2); or
- Add new or modify existing investigator or research staff Financial Conflicts of Interest as determined by Boston Medical Center/Boston University Faculty Review Committee on Research Financial Conflicts of Interest; or
- Affect information provided regarding organizational conflicts of interest; or
- Add new study cohorts and/or new consent forms; or
- Affect template language that was included in the consent form at the time of initial review and approval (see Section 8.1.3.5), or affect consent language previously-approved by a special routing individual or entity during the initial review process

A revised cede letter with the outcome of the evaluation will be provided via the electronic system.

Status Check-In Reports for ceded studies will be evaluated according to Section 10.2.7.4.3.

10.2.3.2 Evaluation of Requests to Serve as the IRB of Record for External Sites

(Revised 8/11/19)
The IRB composition and evaluation of research at external sites follows the standards described in Sections 3 and 10. Information about local requirements and local research context issues (see Section 2.5.2.1) will be incorporated into the evaluation of research at external sites. The IRB will determine whether any management plan for a researcher or research staff conflict of interest is sufficient or whether additional measures are needed to approve the research at the external site.

For multi-site studies that are no greater than minimal risk, the addition of an investigative site is considered a minor modification that may be approved by the expedited process (see Section 10.2.2.4.2.1). For multi-site studies that are greater than minimal risk, at the time of initial review, the Board will make a determination as to the circumstances, if any, where the addition of an investigative site may be approved by the expedited process. If this determination has not been made for a study that is greater than minimal risk, the addition of an investigative site will be reviewed by the Board, and the determination for future additional sites will be made as part of that review.

10.2.4 Exempt Human Subjects Research

10.2.4.1 Request for Exempt Determination

(Revised 10/29/24)
Certain activities that meet the definition of human subjects research are exempt from full IRB review and adherence to the criteria for approval under Section 10.1.1.1. At Boston Medical Center and Boston University Medical Campus, investigators may not make their own determinations that their human subjects research is exempt. Instead, investigators must receive an exempt determination from the Boston Medical Center and Boston University Medical Campus IRB or from the IRB of record with which the Boston Medical Center and Boston University Medical Campus IRB has a reliance agreement for that study (see Section 2.5). To request an exempt determination from the Boston Medical Center and Boston University Medical Campus IRB, Principal Investigators must describe their research involving human subjects in a submission to the IRB (see Section 7.2.2.19), and may indicate that they believe that the research fits into one or more of the Common Rule exempt categories listed in Section 10.2.4.2.1.2 or in one or more of the equivalent protections exempt categories listed in Section 10.2.4.2.2.2. The research must comply with the requirements for protection of participants in exempt research described in Section 10.2.4.3. To request that the Boston Medical Center and Boston University Medical Campus IRB rely on the exempt determination of another IRB, Principal Investigators must submit as described in Section 7.2.2.18. Principal Investigators must receive a formal IRB exempt determination prior to initiating any human subjects research activities.

Studies given an exempt determination from the Boston Medical Center and Boston University Medical Campus IRB prior to January 21, 2019 are given an expiration date of three years after the exempt determination. Studies given an exempt determination on or after January 21, 2019 do not have an expiration date but are required to provide a status check-in every three years (see Section 7.4.3.2). Failure to provide the status check-in by the due date is a deviation (see Section 6.6.5.3) that may be considered continuing noncompliance (see Section 11.4.2). If human subjects research activities have ended, Principal Investigators may close an exempt study at any time by changing the study status to closed in the electronic system (see Section 6.6.6).

For exempt determinations from the Boston Medical Center and Boston University Medical Campus IRB, changes to the research plan must be submitted as an amendment via the electronic system (see Section 7.4.1.2) for review and confirmation of continued exempt status or continued eligibility for a waiver of authorization prior to initiation of the change if the change could alter the IRB determinations, including changes in:

- protections for privacy and confidentiality; or
- funding; or
- recruitment procedures or recruitment materials; or
- information provided for a waiver of authorization for use and disclosure of Protected Health Information (see Section 8.5.2.2); or
- procedures related to the retention of data or samples for extra use (see Section 7.2.2.16.4); or
- procedures that involve the addition of a new study population, or proposed new types of procedures (such as new data collection methods) that were not previously reviewed; or
- relying sites or investigators; for example, the proposed addition of new external sites or new external individual investigators under a reliance agreement

10.2.4.2 Exempt Categories

10.2.4.2.1 Common Rule Exempt Categories

10.2.4.2.1.1 Common Rule Exempt Categories Applicable Prior to January 21, 2019

(Revised 6/20/18)

Research activities in which the only involvement of human subjects will be in one or more of the following categories are eligible for an exempt determination for research given an exempt determination prior to January 21, 2019. These exempt categories do not apply to research involving prisoners.

(1) Research conducted in established or commonly accepted educational settings, that specifically involves normal educational practices. For research submitted for initial exempt determination on or after July 1, 2017, the research must not be likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This exemption includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures [does not apply to children], interview procedures [does not apply to children] or observation of public behavior (including visual or auditory recording) [only applies to research with children when the investigators and research staff do not participate in the activities being observed], if either: (i) The information obtained is recorded in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; or (ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement or reputation.

(3) 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 paragraph (2) of this section, 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.

(4) 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, the investigator does not contact the subjects, and the investigator will not re-identify subjects.

OHRP interprets "existing" as follows:

To qualify for this exempt category, the data, documents, records, or specimens **must be in existence before the project begins**. Following is the edited version of an example given by OHRP. An investigator wants to screen blood samples at a hospital for incidence of HIV by using specimens that were drawn for some other purpose but remain in the hospital laboratory. If the investigator proposes to use specimens that had been drawn prior to the initiation of the research and are, for some reason, "on the shelf," the protocol will qualify as exempt if the other

requirements of (4) are met (i.e., the sources are either publicly available or the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects). If the specimens will be drawn after the start date of the project, the research is not exempt, even though the specimens will be drawn for purposes other than the research, and the research is only using excess blood. The latter study may, however, qualify for expedited review or equivalent protections exempt category 9 if eligible.

(5) Research and demonstration projects which are conducted by or subject to the approval of U.S. Federal 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.

To qualify for this category, studies must also meet the following additional criteria:

- The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act).
- The research or demonstration project must be conducted pursuant to specific federal statutory authority.
- There must be no statutory requirement that the project be reviewed by an Institutional Review Board (IRB).
- The project must not involve significant physical invasions or intrusions upon the privacy of participants.

(6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed; or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

10.2.4.2.1.2 Common Rule Exempt Categories Applicable On or After January 21, 2019

(Revised 9/16/26)

Research activities in which the only involvement of human subjects will be in one or more of the following categories are eligible for an exempt determination, alone or in combination with one or more of the equivalent protections exempt categories (see Section 10.2.4.2.2.2), for research given an exempt determination on or after January 21, 2019. These exempt categories do not apply to research involving prisoners, except research in exempt category (4) that is aimed at involving a broader subject population that only incidentally includes prisoners. In this type of research in exempt category (4), the prisoner requirements in Section 9.3 do not apply. Exempt categories 2(ii), 2(iii), 3(i)(B), and 3(i)(C) require limited IRB review to assess the adequacy of provisions to protect the privacy of subjects and to maintain the confidentiality of the data as part of the exempt determination (see Section 10.2.4.4). Exempt category 4(iii) requires IRB review to grant a waiver of authorization under Section 8.5.2.2.

(1) Research, conducted in established or commonly accepted educational settings, that specifically involves normal educational practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

(2) Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met:

(i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects CANNOT readily be ascertained, directly or through identifiers linked to the subjects;

(ii) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation, and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data; or

(iii) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects CAN readily be ascertained, directly or through identifiers linked to the subjects, and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data.

(3) (i) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met:

(A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects CANNOT readily be ascertained, directly or through identifiers linked to the subjects;

(B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation, and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data; or

(C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects CAN readily be ascertained, directly or through identifiers linked to the subjects, and there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of the data.

(ii) For the purpose of this exemption category, benign behavioral interventions are brief in duration, harmless, painless, not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

(iii) If the research involves deceiving the subjects regarding the nature or purposes of the research, this exemption is not applicable unless the subject authorizes the deception through a prospective agreement to participate in research in circumstances in which the subject is informed that they will be unaware of or misled regarding the nature or purposes of the research.

(4) Secondary research for which consent is not required: Secondary research uses of identifiable private information or identifiable biospecimens, if at least one of the following criteria is met:

(i) reserved (Note that use of identifiable "private" information or identifiable biospecimens that are publicly available does not meet the definition of human subjects research);

(ii) Information, which may include information about biospecimens, is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained directly or through identifiers linked to the subjects, the investigator does not contact the subjects, and the investigator will not re-identify subjects;

(iii) The research involves only information collection and analysis involving the investigator's use of identifiable health information when that use is regulated under 45 CFR parts 160 and 164, subparts A and E, for the purposes of "health care operations" or "research" as those terms are defined at 45 CFR 164.501 or for "public health activities and purposes" as described under 45 CFR 164.512(b). (Note: this exemption is only available if the identifiable health information remains within a covered entity, and requires IRB review to grant a waiver of authorization under Section 8.5.2.2); or

(iv) The research is conducted by, or on behalf of, a Federal department or agency using government-generated or government-collected information obtained for nonresearch activities, if the research generates identifiable private information that is or will be maintained on information technology that is subject to and in compliance with section 208(b) of the E-Government Act of 2002, 44 U.S.C. 3501 note, if all of the identifiable private information collected, used, or generated as part of the activity will be maintained in systems of records

subject to the Privacy Act of 1974, 5 U.S.C. 552a, and, if applicable, the information used in the research was collected subject to the Paperwork Reduction Act of 1995, 44 U.S.C. 3501 et seq.

(5) Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads (or the approval of the heads of bureaus or other subordinate agencies that have been delegated authority to conduct the research and demonstration projects), and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs. Such projects include, but are not limited to, internal studies by Federal employees, and studies under contracts or consulting arrangements, cooperative agreements, or grants. Exempt projects also include waivers of otherwise mandatory requirements using authorities such as sections 1115 and 1115A of the Social Security Act, as amended.

(i) Each Federal department or agency conducting or supporting the research and demonstration projects must establish, on a publicly accessible Federal website or in such other manner as the department or agency head may determine, a list of the research and demonstration projects that the Federal department or agency conducts or supports under this provision. The research or demonstration project must be published on this list prior to commencing the research involving human subjects.

(6) Taste and food quality evaluation and consumer acceptance studies:

(i) If wholesome foods without additives are consumed, or

(ii) If a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Note: exempt categories (7) and (8) are reserved.

10.2.4.2.2 Equivalent Protections Exempt Categories

10.2.4.2.2.1 Equivalent Protections Exempt Categories Applicable Prior to January 21, 2019

(Revised 6/20/18)

For studies eligible for equivalent protections (see Section 2.1.2), if the research is no greater than minimal risk (including minimal risk of invasion of privacy and breach of confidentiality), if the only involvement of human subjects will be in one or more of the following equivalent protections categories, and if the research complies with the applicable requirements of Section 10.2.4.3, then the research is eligible for an exempt determination for research given an exempt determination prior to January 21, 2019. When another institution has agreed to rely on the Boston Medical Center and Boston University Medical Campus IRB (see Section 2.5), these exempt categories will not be used. Also, these exempt categories do not apply to research involving prisoners.

(7) Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met: (A) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; or (B) Any disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (C) The IRB determines that confidentiality procedures will be adequate to protect information obtained that is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects. For the purpose of this category, benign behavioral interventions are brief in duration, harmless, painless,

not physically invasive, not likely to have a significant adverse lasting impact on the subjects, and the investigator has no reason to think the subjects will find the interventions offensive or embarrassing. Provided all such criteria are met, examples of such benign behavioral interventions would include having the subjects play an online game, having them solve puzzles under various noise conditions, or having them decide how to allocate a nominal amount of received cash between themselves and someone else.

(8) Research with children involving survey procedures, interview procedures, or observation of public behavior where the investigators or research staff participate in the activities being observed.

(9) Research involving the study of materials (data, documents, records, or specimens) that have been or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

(10) Research involving the study of materials (data, documents, records, or specimens) that have been collected for research purposes when the consent for the research does not preclude such additional research.

(11) Research involving Quality Improvement/Quality Assurance where:

- All patients who get an intervention are expected to benefit; and
- All measurements that are collected are to determine the effect of the process change; and
- All patients involved in the intervention receive standard care at a minimum; and
- The intervention meets evidence-based or consensus-based quality standards; and
- Confidentiality protections are appropriate to the sensitivity of the data collected; and
- Obtaining consent from the patients is not practicable because the change or intervention will be carried out in a clinical setting where there is no meaningful way for patients to opt out of receiving the intervention.

(12) Research involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) where the IRB determines that the confidentiality procedures are adequate to protect information that is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects.

(13) Minimal risk research without external funding with adult subjects able to provide abbreviated consent where the research does not qualify for categories (7) through (12).

10.2.4.2.2.2 Equivalent Protections Exempt Categories Applicable On or After January 21, 2019

(Revised 9/16/26)

For studies eligible for equivalent protections (see Section 2.1.2), if the research is no greater than minimal risk (including minimal risk of invasion of privacy and breach of confidentiality), if the only involvement of human subjects will be in one or more of the following equivalent protections categories, alone or in combination with one or more of the Common Rule exempt categories (see Section 10.2.4.2.1.2), and if the research complies with the applicable requirements of Section 10.2.4.3, then the research is eligible for an exempt determination for research on or after January 21, 2019. Equivalent protection exempt categories will not be used:

1. When another institution has agreed to rely on the Boston Medical Center and Boston University Medical Campus IRB (see Section 2.5), or 2. For studies initially submitted on or after July 1, 2019, when a study involves data that identifies at least one subject as a patient of a specialty substance use disorder clinic or provider.

Research in exempt categories (9), (10), and (11) may involve prisoners if the research is aimed at involving a broader subject population that only incidentally includes prisoners. In these instances, the prisoner requirements in Section 9.3 do not apply. Exempt categories (12) and (13) do not apply to research involving prisoners.

Research in exempt categories (9), (10), (12), and (13) may involve the retention of samples or data, meaning samples (biological specimens with associated data) or data that will be retained for extra use by the study investigator(s) or by other investigators.

(9) Research involving the study of materials (data, documents, records, or specimens) that have been or will be collected solely for nonresearch purposes.
(10) Research involving the study of materials (data, documents, records, or specimens) that have been collected for research purposes when the consent for the research does not preclude such additional research.
(11) Research involving Quality Improvement/Quality Assurance where:
- All patients who get an intervention are expected to benefit; and
- All measurements that are collected are to determine the effect of the process change; and
- All patients involved in the intervention receive standard care at a minimum; and
- The intervention meets evidence-based or consensus-based quality standards; and
- Confidentiality protections are appropriate to the sensitivity of the data collected; and
- Obtaining consent from the patients is not practicable because the change or intervention will be carried out in a clinical setting where there is no meaningful way for patients to opt out of receiving the intervention.

(12) Research with children involving survey procedures, interview procedures, or observation of public behavior where the investigators or research staff participate in the activities being observed.
(13) Minimal risk research without external funding with adult subjects who have the capacity to consent and provide abbreviated consent where the research does not qualify for categories (9) through (12).

10.2.4.3 Protection of Participants in Exempt Research

(Revised 6/28/24)
Participants in exempt human subjects research are protected by training requirements, disclosure requirements, and IRB review. All investigators and research staff who will have contact with subjects or their identifiable information must have up-to-date human subjects training and must be included as study personnel in the electronic system. The existence of Significant Financial Interests of all those responsible for the design, conduct, or reporting of the proposed research must be disclosed in the IRB submission and any financial conflicts of interest must be resolved prior to issuance of an exempt determination (as for non-exempt research, see Section 6.5).

The requirements in the remainder of this section apply to exempt determinations provided by the Boston Medical Center and Boston University Medical Campus IRB. When an exempt determination is provided by another IRB of record, the research must comply with the requirements for exempt research of the IRB of record.

The IRB review of an exempt submission (see Section 7.2.2.19) includes evaluation of the adequacy of the Principal Investigator's plans for protecting subject confidentiality (including handling of PHI under HIPAA), special protections of any vulnerable subjects, disclosing any costs of participating, and avoiding undue influence in any plans for compensation.

If the exempt research involves obtaining information through intervention or interaction with subjects, "abbreviated consent" must be obtained. The abbreviated consent must disclose:
- that this is a research study; and
- that participation is voluntary; and
- the purpose; and
- what the subjects are being asked to do; and
- confidentiality protections; and
- how long participation is expected to take; and
- a disclosure if the subject will be audio- or video-taped; and
- how to contact an investigator or research staff member for questions about the study.

Abbreviated consent does not require a signature. However, if the study requires authorization for use and disclosure of PHI (see Section 8.5), a signature must be obtained either on a separate authorization

form or on an authorization combined with the abbreviated consent, unless the study qualifies for a waiver or alteration of authorization under Section 8.5.2.2.

For exempt research involving interactions with children under exempt category (1), parents must be notified about the research with the same disclosures as for abbreviated consent and be given the opportunity to opt out.

For exempt research under equivalent protections exempt category (7) or (13) applicable prior to January 21, 2019 or under exempt category (3) or equivalent protections exempt category (13) applicable on or after January 21, 2019, if the research involves deceiving the subjects regarding the nature or purposes of the research, abbreviated consent must include that subjects will be unaware of or misled regarding the nature and purpose of the research and subjects must be debriefed at the end of their participation.

For exempt research involving surveys or interviews with children under equivalent protections exempt category (8) applicable prior to January 21, 2019 or under equivalent protections exempt category (12) applicable on or after January 21, 2019, child assent and parental permission must be obtained with the same disclosures as for abbreviated consent.

For exempt research involving quality improvement under equivalent protections exempt category (11), abbreviated consent must be obtained from subjects (including healthcare professionals) participating in interviews, focus groups, surveys, or training, but not for patients affected by the Quality Improvement/Quality Assurance intervention.

For exempt research involving the retention of samples or data for extra use by the study investigator(s) or by other investigators, the abbreviated consent must contain the elements of informed consent for research involving repositories or retention of samples or data (see Section 8.2.5). Abbreviated consent for the retention of samples or data for extra use does not require a signature. However, if agreeing to retention of samples or data for extra use is optional, the study team is required to collect and maintain documentation that tracks whether each subject opted in or opted out of permitting retention of their samples or data for extra use.

For exempt research involving interactions with subjects with limited English proficiency, abbreviated consent must be presented in language understandable to the subject. The IRB does not review the translated abbreviated consent language nor other translated study materials.

10.2.4.4 Review of Requests for an Exempt Determination

(Revised 6/20/18)
An experienced IRB staff person performs administrative review of exempt initial, amendment, and renewal (Progress Report or Status Check-In Report) submissions to determine whether the criteria are satisfied for initial submissions and continue to be satisfied for amendments and renewals. In some cases a second experienced reviewer or a board member also reviews the submission. No reviewer may have a conflict of interest in the research (see Section 3.9). For research qualifying for exempt categories 2(iii) and 3(i)(C) applicable on or after January 21, 2019 (see Section 10.2.4.2.1.2), the review will be performed by an Expediter who will document in the electronic system that there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data.

During the review of the submission, Principal Investigators may be asked for clarifications/changes or to provide additional information if the research requires approval rather than an exempt determination. If it is determined that the study meets or continues to meet the exempt criteria, an outcome letter is provided via the electronic system.

The exempt determination letter includes the following information:
- Study name (with version number and/or date); and
- Notice of exempt determination; and
- Review type; and

- Date of action; and
- Expiration or status check-in due date; and
- Funding source; and
- Study-specific determinations and findings:
  - Exempt category; and
  - Use of PHI; and
- Reminder of Principal Investigator responsibilities; and
- Reminders that any changes to the research plan that would possibly alter the exempt determination must be submitted to the IRB for review and confirmation of continued exempt status prior to initiation of the change and that minor changes to the study that do not affect the exempt determination are only submitted to the IRB if and when the exempt determination is renewed; and
- For studies with equivalent protections, notification that the Principal Investigator must report obtaining external funding to the IRB within 14 days of learning of the external funding.

10.2.4.5 Evaluation of Amendments and Progress Reports for Exempt Studies

(Revised 3/2/25)
Amendments and Progress Reports (for research given an exempt determination prior to January 21, 2019) will be evaluated to determine whether the research continues to qualify for an exempt determination. If so, the Principal Investigator will be provided with a new Exempt Determination letter, which will include the new status check-in due date for Progress Reports. If not, the Principal Investigator may be asked to provide additional information for the research to be reviewed as non-exempt human subjects research.

10.2.5 Activities Not Involving Research with Human Subjects

10.2.5.1 Research on Individuals Where Public or Anonymous Information or Biospecimens are Obtained without Interaction with Subjects

(Revised 4/26/24)
Research that does not involve human subjects does not require IRB review or adherence to the criteria for approval under Section 10.1.1.1 or submission to the IRB except as specified in this section.

The definition of a human subject in Section 13 includes “a living individual about whom a researcher… obtains, uses, studies, analyzes, or generates identifiable private information about the individual or identifiable biospecimens.” The definition also provides that “Identifiable private information is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information” and “An identifiable biospecimen is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.” In some cases the “readily ascertainable” standard can be met because disclosure of identifiers is prohibited by law, such as a state data source or archive where a law would prohibit the release of identifiers. Also, data obtained from a repository can be determined to have met the “readily ascertainable” standard if there is a restrictive written agreement between the repository and the recipient that prevents disclosure of identifiers to the recipient.

Because the standards for identifiability under the Common Rule and HIPAA are based upon different criteria, a study involving health information that includes any data element that is considered a Health Information Identifier under HIPAA (see the definition of Health Information Identifiers in Section 13) must be submitted to the IRB even if the study could qualify as not human subjects research if the identity of the subjects was not readily ascertainable. The IRB will determine whether this study requires an authorization (see Section 8.5.1), a designation as involving a Limited Data Set (see Section 8.5.2.1), or a waiver of authorization (see Section 8.5.2.2).

For recipient studies involving use of data or samples obtained from a repository or from a study involving retention of data or samples for extra use, IRB review is required if the releasing study involves the collection and maintenance of non-anonymous data and the recipient investigator is also an investigator

on the releasing study. This IRB review is required even if the recipient data or samples only include coded data or samples that are not "readily ascertainable" and do not include any Health Information Identifiers under HIPAA. This is because if the data maintained by the releasing study is non-anonymous, the recipient investigator who is also an investigator on the releasing study has access to the non-anonymous data as part of their role as an investigator on the releasing study, and therefore the recipient study meets the definition of human subjects research (see Section 13).

Effective April 26, 2024, any study that will involve the use of publicly-available information about individual persons must be submitted to the IRB.

10.2.5.2 Activities That Do Not Constitute Research

10.2.5.2.1 How Research is Defined

(Revised 6/29/17)
The definition of research is given in Section 13: "**Research** is defined as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. For purposes of this definition, a systematic investigation is the use of a predetermined method to gain information by collecting and analyzing data. Generalizable knowledge is conclusions that can be applied to circumstances outside of the specific instances of the investigation." Activities that meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program that is considered research for other purposes. For example, some demonstration and service programs may include research activities, and some investigators may carry out research on activities that themselves do not constitute research, such as the public health, criminal justice, or security activities listed below.

An activity that is not intended to develop or contribute to generalizable knowledge does not meet the definition of research.

The IRB does not consider the following activities to be research:

(1) Scholarly and journalistic activities (e.g., oral history, journalism, biography, literary criticism, legal research, and historical scholarship), including the collection and use of information, that focus directly on the specific individuals about whom the information is collected; and
(2) Public health surveillance activities, including the collection and testing of information or biospecimens, conducted, supported, requested, ordered, required, or authorized by a public health authority. Such activities are limited to those necessary to allow a public health authority to identify, monitor, assess, or investigate potential public health signals, onsets of disease outbreaks, or conditions of public health importance (including trends, signals, risk factors, patterns in diseases, or increases in injuries from using consumer products). Such activities include those associated with providing timely situational awareness and priority setting during the course of an event or crisis that threatens public health (including natural or man-made disasters); and
(3) Collection and analysis of information, biospecimens, or records by or for a criminal justice agency for activities authorized by law or court order solely for criminal justice or criminal investigative purposes; and
(4) Authorized operational activities (as determined by each agency) in support of intelligence, homeland security, defense, or other national security missions.

The IRB does not require a submission for activities not considered to be research, unless the investigator wishes to obtain an official letter from the IRB with the determination of Not Human Subjects Research (see Section 10.2.5.4).

10.2.5.2.2 Quality Improvement and Quality Assurance Activities

(Revised 6/22/21)
Quality Improvement/Quality Assurance (QI/QA) activities are not considered to meet the definition of research if:

- When the intervention involves patients, all patients who get the intervention are expected to benefit; and
- The purpose of measurement related to the QI/QA project is to determine the effect of process change, measure performance, or for submission to an authorized national or state registry and/or database that has the intent to improve the delivery of clinical care; and
- The purpose of the QI/QA project is to improve institutional processes or delivery of care consistent with established quality standards; and
- When the initiative involves patients, all patients involved in the initiative will receive standard of care at a minimum; and
- The project involves systemic data collection to monitor and compare performance to defined standards; and
- The project will be described as “quality improvement” or “quality assurance” in public presentations, academic curriculum vitae, publications, and/or other representations to any third party audience, with a planned statement similar to: “This project was undertaken as a Quality Improvement Initiative at Boston Medical Center, and as such was not formally supervised by the Institutional Review Board per their policies.”; and
- There is an agreement with the leadership of the clinical practice unit in which the project will take place (the unit in the hospital, clinic, division, or care group) that this is a QI/QA project that will be undertaken to improve institutional processes or delivery of care; and
- The project will be conducted by clinicians and staff where the project will take place, and involves staff and/or patients of Boston Medical Center or of the Boston University Dental Clinic; and
- The intent of the project is NOT to test a novel hypothesis, answer a research question or replicate another researcher’s original study; and
- The project does NOT seek to test interventions, treatments or practices that are not currently considered standard of care in any existing practice (neither consensus-based, nor evidence-based); and
- The project does NOT involve withholding any aspect of standard of care; and
- The intent of the project is NOT to design or develop a new standard of care or benchmark; and
- No physician or staff member will be blinded to any aspect of the patient’s care; and
- No persons (including patients and investigators) will be exposed to risks beyond those involved in clinical care that are greater than minimal risk; and
- The project does NOT involve a research design (e.g., randomization) that over-rides clinical decision-making; and
- The project does NOT involve using a medication or medical device or procedure outside of usual medical practice; and
- The project does NOT involve funding from a research grant or other research agreement; and
- The project will NOT be described as research in representations such as publications, presentations, or academic dossier; and
- Chart reviews are NOT the only activities of the entire QI/QA project.

Projects that do not meet all of the above criteria should be submitted to the IRB for review.

Communications with investigators regarding QI/QA projects will note that all PHI must be transmitted, stored, analyzed, or otherwise exist only on HIPAA-compliant electronic systems that meet Boston Medical Center’s or Boston University’s security standards for protection of PHI.

10.2.5.2.3 Case Reports and Case Series

(Revised 12/19/16)

A case report is a detailed report of the diagnosis, treatment, response to treatment, and follow-up after treatment of an individual patient. A case series is group or series of case reports involving patients who were given similar treatment. Case reports and case series usually contain demographic information about the patient(s), for example, age, gender, ethnic origin. When information on more than three patients is included, the case series is considered to be a systematic investigation designed to contribute to generalizable knowledge, and therefore to require IRB review.

The IRB website contains information about complying with requirements under HIPAA for case reports and case series, whether or not IRB submission is required.

10.2.5.3 Review of Training Grants

(Revised 2/24/16)
The parent grant of a training grant does not describe specific human subjects research activities. Therefore, the Principal Investigator on the training grant is not required to submit the training grant to the IRB for review (see Section 10.2.5). However, any human subjects research performed by an individual supported by the training grant must be approved as a separate IRB submission, either as a stand-alone submission or as a request for internal study personnel changes as an amendment to an already-approved study.

10.2.5.4 Requests for a Not Human Subjects Research Determination

(Revised 9/15/20)
A Principal Investigator who is required to submit a Not Human Subjects Research project (see Section 10.2.5.1) or who requires a determination by the IRB to verify that a proposed activity does not constitute human subject research must submit a request that contains sufficient description of the activity so that the IRB can make an appropriate determination about whether the study qualifies as Not Human Subjects Research (see Section 7.2.2.17). An experienced IRB staff person performs administrative review of Not Human Subjects Research initial and amendment submissions to determine whether the criteria are satisfied for initial submissions and continue to be satisfied for amendments. For submissions of Not Human Subjects Research projects involving publicly-available information, the IRB may request an expert opinion; for example, consultation about projects involving social media may be requested from the relevant BMC or BU Medical Campus Communications Department. In addition, the IRB may ask the Department Chair and/or Section Chief to provide a specific assurance that the project can and should be conducted within their department.

During the review of the submission, Principal Investigators may be asked for clarifications/changes or to provide additional information if the research requires an exempt determination or approval rather than a determination of Not Human Subjects Research. Subsequent alterations that might change the determination that the study does not constitute human subjects research must be submitted as an amendment via the electronic system (see Section 7.4.1.2) for review and confirmation of continued Not Human Subjects Research status prior to initiation of the change.

If it is determined that the study does not constitute human subjects research, an outcome letter is provided via the electronic system.

The Not Human Subjects Research letter includes the following information:

- Study name (with version number and/or date); and
- Notice of Not Human Subjects Research determination; and
- Review type; and
- Date of action; and
- Funding source; and
- Study-specific determinations and findings:
  - Use of PHI; and
  - Approved HIPAA Data Sets (if applicable); and
- Reminder of Principal Investigator responsibilities; and
- Reminders that any changes to the research plan that would possibly alter the Not Human Subjects Research determination must be submitted to the IRB for review and confirmation of continued Not Human Subjects Research status prior to initiation of the change and that minor changes to the study that do not affect the Not Human Subjects Research determination do not need to be submitted to the IRB; and

- A statement that any publication concerning this project must NOT say that the IRB "approved" the research or "waived consent" and that if a statement is required in the publication concerning IRB review, the following language should be used: "The IRB reviewed the research and made the determination that it was not human subjects research and therefore had no requirement to obtain consent.

10.2.6 Activities where Boston Medical Center and Boston University Medical Campus are not Engaged in Human Subjects Research

(Revised 10/23/22)
Investigators may submit a request for IRB review of activities that they believe do not make Boston Medical Center or Boston University Medical Campus engaged in research (see Section 2.4). Investigators are required to submit if they are facilitating the targeted recruitment of students, trainees, or employees or the direct contact by members of the external research team with or the release of PHI from patients at Boston Medical Center or Boston University Henry M. Goldman School of Dental Medicine (see Section 2.4). The submission requires an explanation of the project and the study activities that are occurring at Boston Medical Center or Boston University Medical Campus (see Section 7.2.2.17). An experienced IRB staff person performs administrative review of initial and amendment submissions to determine whether the criteria for non-engagement are satisfied for initial submissions and continue to be satisfied for amendments. The IRB staff person will consult with the Chief Medical Officer or designee for projects involving recruitment of Boston Medical Center patients, trainees, or employees, with the Dean of the Henry M. Goldman School of Dental Medicine for projects involving recruitment of dental patients, students, trainees, or employees, and with the Dean of the Chobanian & Avedisian School of Medicine or School of Public Health for projects involving recruitment of their students, trainees, or employees. The IRB may ask for additional information, notify the Principal Investigator that a different review path is required, or determine that neither Boston Medical Center nor Boston University Medical Campus are engaged in the research.

If it is determined that the study does not engage Boston Medical Center or Boston University Medical Campus in human subjects research, an outcome letter is provided via the electronic system.

The Not Engaged letter includes the following information:

- Study name (with version number and/or date); and
- Notice of Not Engaged determination; and
- Date of action; and
- Funding source; and
- Study-specific determinations and findings:
  - Use of PHI; and
  - Approved HIPAA Data Sets (if applicable); and
- Reminders that any changes to the research plan that would possibly alter the Not Engaged determination must be submitted to the IRB for review and confirmation of continued Not Engaged status prior to initiation of the change and that minor changes to the study that do not affect the Not Engaged determination do not need to be submitted to the IRB.

10.2.7 Administrative Review

10.2.7.1 Review of Requests to Change Study Personnel

(Revised 10/20/23)
Requests to change the Principal Investigator or Supervising Principal Investigator for non-exempt research are reviewed through the expedited procedure in Section 10.2.2.4.2.1. Requests to change the Principal Investigator or Supervising Principal Investigator for exempt research or ceded research, or requests to change other study personnel for all types of research, are administratively reviewed by an experienced member of the IRB staff, who may or may not be an Expediter. The administrative review will determine whether all added personnel satisfy the requirements for training and disclosure of Conflicts of Interest. If the requirements are not satisfied, the Principal Investigator will be asked for additional

information or clarification. When all requirements are met, the IRB will transmit an outcome letter informing the Principal Investigator that the updates to Internal Study Personnel have been given administrative approval.

The internal study personnel changes letter includes the following information:

- Study name (with version number and/or date); and
- Review type; and
- Action; and
- Date of action; and
- Expiration or status check-in due date (except for ceded review research); and
- Amendment description; and
- Reminders of training and Conflict of Interest requirements and overall Principal Investigator responsibilities.

10.2.7.2 Review of Final Reports

(Revised 10/02/21)

Final Reports are reviewed by an experienced member of the IRB staff, who may or may not be an Expediter. The staff member evaluates whether the study qualifies for closure, in relation to the plans for destroying or anonymizing study data, and whether any new risks have been identified. If the study does not qualify for closure, additional information or submissions may be requested from the Principal Investigator and the Final Report may be referred to an Expediter or to the convened IRB for further action.

For non-exempt research, the IRB will transmit an outcome letter informing the Principal Investigator that the study has been closed, referencing specific responsibilities that continue for closed studies. The effective date of the closure is the date that the properly completed form was received by the IRB, to allow for batch processing of outcome letters.

The closure letter includes the following information:

- Study name (with version number and/or date); and
- Notice of study closure; and
- Review type; and
- Date of action; and
- Specific responsibilities for closed studies:
  - Reminder of allowable activities after closure; and
  - A link to requirements to obtain approval for any removal of data or samples (https://www.bumc.bu.edu/ohra/hrpp-policies/hrpp-policies-procedures/#6.6.8); and
  - Reminder of requirements for post-closure reporting.

10.2.7.3 Review of Changes to Contact Information

(Revised 1/17/18)

Requests to change contact information in consent forms and other subject materials are administratively reviewed by an experienced member of the IRB staff, who may or may not be an Expediter. The administrative review will determine whether the changes to the consent forms and other subject materials are limited to changes in contact information, and whether the plan for notifying already-enrolled subjects is appropriate. If either requirement is not satisfied, the Principal Investigator will be asked for additional information or clarification, and may be asked to submit for review through the expedited procedure in Section 10.2.2.4.2.1. When all requirements are met, the IRB will transmit an outcome letter informing the Principal Investigator that the new materials have been given administrative approval.

The changes in contact information letter includes the following information:

- Study name (with version number and/or date); and
- Review type; and
- Action; and

- Date of action; and
- Expiration or status check-in due date; and
- Amendment description; and
- Reminders of training and Conflict of Interest requirements and overall Principal Investigator responsibilities.

10.2.7.4 Review of Status Check-In Reports

10.2.7.4.1 Review of Status Check-In Reports for Research Approved without an Expiration Date

(Revised 3/2/25)
An experienced IRB staff person performs administrative review of Status Check-In Reports for research approved without an expiration date.

Status Check-In Reports for research approved without an expiration date will be evaluated to determine whether any information about minor deviations and/or subject complaints indicates a need for IRB actions, including obtaining more information from the Principal Investigator, requiring the Principal Investigator to make changes, approving the study with an expiration date, scheduling a targeted audit (see Section 11.3.4), and suspending or terminating approval for the study (see Section 11.5). Any such actions will be communicated to the Principal Investigator through the electronic system. If no such actions are required, Status Check-In Reports will be evaluated to determine whether the research continues to qualify for approval without an expiration date. If so, the Principal Investigator will be notified through the electronic system with the new status check-in due date. If not, the Principal Investigator will be asked to submit a Progress Report that will be reviewed as described in Section 10.1.2.

If the Status Check-In Report indicates a pattern of short form use that suggests that the Principal Investigator should anticipate further enrollment of subjects with limited English proficiency, the Principal Investigator will be contacted and asked to submit an amendment to instead use a full translation of the consent form for this population (see Section 8.4.5).

If the Status Check-In Report indicates that changes have been made in an approved study without reporting to the IRB and the experienced IRB staff person conducting the review is an Expediter, the IRB staff person reviewer will evaluate the Status Check-In Report in conjunction with the associated Change Request and Amendment submission and the Reportable Events and New Information submission, including referral to the IRB Director, Chair, or convened panel meeting as appropriate. If the experienced IRB staff person conducting the review is not an Expediter, they will refer the review of the associated Change Request and Amendment submission and the Reportable Events and New Information submission to an Expediter. The reviewer will communicate any actions to the Principal Investigator.

10.2.7.4.2 Review of Status Check-In Reports for Research Given an Exempt Determination On or After January 21, 2019

(Revised 3/2/25)
Status Check-In Reports for research given an exempt determination on or after January 21, 2019 will be evaluated to determine whether the research continues to qualify for an exempt determination. If so, the Principal Investigator will be provided with a new Exempt Determination letter, which will include the new status check-in due date. If not, the Principal Investigator may be asked to provide additional information for the research to be reviewed as non-exempt human subjects research.

10.2.7.4.3 Review of Status Check-In Reports for Ceded Studies

(Revised 3/2/25)
Status Check-In Reports for ceded studies will be evaluated to determine whether any information was not reported as required and whether any follow-up actions are required. A revised cede letter with the new status check-in due date will be provided via the electronic system.

10.3 Review Decisions

10.3.1 Voting Process for Review Decisions

(Revised 2/24/17)
During convened meetings, the IRB may vote to approve, conditionally approve, defer, or disapprove all research activities by the following process:

- All persons with a conflict of interest are required to leave the room before final discussion and a vote is called; and
- A board member makes a motion to approve, conditionally approve, defer, or disapprove a submission or a board action; and
- Another board member seconds the motion. If no one seconds the motion then the motion dies without a vote; and
- If the motion is seconded, then the Chair calls for a vote on the motion that is on the table; and
- For the motion to pass it must be agreed upon by a majority of the voting members present (including those who abstain and those who recuse themselves unless those who recuse are replaced by appropriate alternates).

10.3.2 Types of Review Decisions

10.3.2.1 Approval

(Revised 8/30/16)
Approval indicates that the submission has been approved as submitted requiring no changes, additions, or modifications.

10.3.2.2 Conditional Approval

(Revised 11/06/17)
Conditional approval indicates that the convened IRB is able, based upon the assumption that the conditions specified by the convened IRB are satisfied, to make all of the determinations required for approval under Section 10.1.1.1.

The conditions specified by the convened IRB are recorded in the electronic system, referenced in the minutes, and communicated as stipulations to the Principal Investigator via the electronic system. The Principal Investigator must submit a revised submission that responds to each condition specified by the IRB. The IRB Chair, the Chair's designee, or an Expediter may subsequently approve a submission that has been revised in response to a conditional approval if all the stipulations are resolved, or may return the submission to the convened IRB otherwise.

Conditional approval is not approval of a submission, and no human subject research activities described in the submission (including changes described in amendment submissions and continuation of research in progress report submissions) may occur until the Principal Investigator has been notified that the conditions are satisfied and the submission is approved.

10.3.2.3 Deferral

(Revised 11/06/17)
Deferral indicates that substantive clarifications or changes are requested that are directly related to the requirements under Section 10.1.1.1.

The concerns and requirements of the board of a deferred submission are recorded in the electronic system, referenced in the minutes, and communicated as stipulations to the Principal Investigator via the electronic system. The Principal Investigator must submit a revised submission that responds to each IRB

stipulation point by point. A subsequent review by the convened IRB of the complete submission with the revised material is necessary to determine approval.

10.3.2.4 Disapproval

(Revised 11/06/17)
Disapproval indicates that the convened IRB has found one or more major flaws in the design of the research, or other problem(s) so great, that the study must be redesigned to address the issues. The concerns of the board about a disapproved submission are recorded in the electronic system, referenced in the minutes, and communicated to the Principal Investigator via the electronic system. The disapproval letter provides the written notification of the reasons for the IRB's decision to disapprove the study. The disapproval letter also notifies Principal Investigators that they have 30 days to appeal the disapproval by responding in writing through the electronic system, and may request an opportunity to appear before the IRB.

10.3.2.5 Acknowledgement

(Revised 8/30/16)
The IRB will acknowledge a Reportable Events and New Information submission (see Section 7.4.5) when no additional board action is required. The acknowledgement letter will include any additional IRB determinations made concerning the submission.

10.3.2.6 Board Action

(Revised 8/30/16)
The IRB may suspend or terminate approval for a study as described in Section 11.5, or impose conditions on the research as described in Sections 11.4.3.5 and 11.4.3.6. These board actions are communicated to the Principal Investigator through a Board Action letter, which includes any additional IRB determinations made concerning the study.

10.4 Review Considerations

10.4.1 Review Intervals

10.4.1.1 Determination of Expiration Dates

(Revised 9/22/19)
The IRB determines the expiration date of approval based on the degree of risk. Certain low-risk research is eligible for being given no expiration date (see Sections 10.4.1.4.1 and 10.4.1.4.2). Principal Investigators of research approved without an expiration date must meet all other IRB requirements, and must submit a Status Check-In Report every three years after the date of approval as long as the research continues. The expiration date or status check-in due date is recorded in the electronic system and referenced in the minutes for approvals by the convened IRB. Outcome letters state the study expiration date or the status check-in due date.

For research approved prior to January 21, 2019 and not eligible for equivalent protections (see Section 2.1.2), the expiration date is no later than one year past the effective date of approval. For research approved prior to January 21, 2019 and eligible for equivalent protections, the expiration date may be up to three years past the effective date of approval for certain categories (see Section 10.4.1.3).

For research approved on or after January 21, 2019 and not qualifying for a continuing review exception listed in Section 10.4.1.4.1 or 10.4.1.4.2 and for clinical investigations under FDA jurisdiction, the expiration date is no later than one year past the effective date of approval.

Research projects otherwise eligible for no expiration date (see Sections 10.4.1.4.1 and 10.4.1.4.2) may be given an expiration date if the Boston Medical Center and Boston University Medical Campus IRB is serving as the IRB of record for one or more external sites see Section 2.5) and determines that annual

continuing review will provide appropriate additional oversight (for example, if subjects are being recruited at the external site). The IRB may give an expiration date to other research projects eligible for no expiration date based on the need for additional oversight. When an expiration date for a research study is given for studies eligible for no expiration date, the rationale is recorded in the electronic system and referenced in the minutes for approvals by the convened IRB.

For initial approval, the effective date of approval is the date upon which the convened IRB or an Expediter issued approval, or the date upon which the Principal Investigator satisfied the stipulations of a conditional approval by the convened IRB.

For continuing review, the effective date of approval may be up to 30 days after the date upon which the convened IRB or an Expediter issued the approval, in order to maintain the same day and month of expiration (anniversary date).

Expiration of IRB approval occurs at midnight on the last day of the approval period.

10.4.1.2 Studies with Review Intervals Less than One Year

(Revised 5/30/17)
The IRB may determine that certain studies must be reviewed more often than once a year based upon the initial review or continuing review. Additionally, the IRB may require review after a predetermined number of subjects have been enrolled into the study. Study-specific justifications for an approval period of less than one year will be recorded in the electronic system and referenced in the minutes for approvals by the convened IRB.

Studies that might be considered for review more frequently than once per year include, but are not limited to, studies involving:

- The use of special populations, including those identified in Section 9 as well as other special populations identified by the IRB; or
- The withdrawal of standard treatment or therapy regardless of replacement by experimental treatment, when there is a high risk of mortality or morbidity; or
- Significant risks or potential serious impairment to the subject; or
- Risk when there is no potential benefit to the subject; or
- Invasive surgical procedures; or
- Gene transfer research; or
- Phase I studies; or
- Research by investigators who have required corrective action in previous studies.

10.4.1.3 Studies Approved Prior to January 21, 2019 with Review Intervals Greater than One Year

(Revised 6/20/18)
Prior to January 21, 2019, the IRB generally assigns a three-year approval period for studies eligible for equivalent protections (see Section 2.1.2) in the following categories:

- Studies initially approved by the expedited procedure (see Section 10.2.2.4.1); and
- Studies initially approved by the convened IRB when the convened IRB determines that the study is no greater than minimal risk; and
- Studies approved at continuing review in expedited categories 8(a), 8(c), and 9 (see Section 10.2.2.4.3.1).

The IRB assigns an approval period of less than three years to a study in the above categories if warranted by the magnitude and likelihood of risks or by the qualifications, experience, or history of compliance of the researchers. Study-specific justifications when studies in the above categories are given an approval period of less than three years are recorded in the electronic system and referenced in the minutes for approvals by the convened IRB.

For studies with approval periods of three years, a notice will be sent via the electronic system at one and two years after approval reminding the Principal Investigator that no changes may be made without prior IRB approval and that the study must be closed when human research activities have ceased.

10.4.1.4 Studies Approved Without Expiration Dates

10.4.1.4.1 Studies Approvable Without Expiration Dates under the Common Rule On or After January 21, 2019

(Revised 6/20/18)
On or after January 21, 2019, at the time of initial or continuing review, the IRB may approve studies in the following categories without an expiration date:

- Research eligible for expedited review in accordance with Section 10.2.2.4.1.2; and
- Research determined to be exempt in conjunction with a limited IRB review in accordance with Section 10.2.4.2.1.2; and
- Research that has progressed to the point that it involves only one or both of the following, which are part of the IRB-approved study:
  (A) Data analysis, including analysis of identifiable private information or identifiable biospecimens, or
  (B) Accessing follow-up clinical data from procedures that subjects would undergo as part of clinical care.

10.4.1.4.2 Studies Approvable Without Expiration Dates under Equivalent Protections On or After January 21, 2019

(Revised 6/20/18)
For studies eligible for equivalent protections (see Section 2.1.2), at the time of initial or continuing review, the IRB may approve studies in the following categories without an expiration date:

- Research eligible for equivalent protections expedited review in accordance with Section 10.2.2.4.1.3; and
- Research not listed in an expedited review category in Section 10.2.2.4.1.2 or 10.2.2.4.1.3, but where 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.

10.4.1.4.3 Requirements for Studies Approved Without Expiration Dates

(Revised 1/17/18)
Studies approved without expiration dates must comply with all applicable requirements, including following the approved study plan, not making changes without prior IRB approval except if necessary for the safety of the subjects, assuring that all study personnel maintain current training, and reporting information relevant to subjects' rights, safety, and well-being.

For studies with no expiration of approval, a notice will be sent via the electronic system at one and two years after approval reminding the Principal Investigator that no changes may be made without prior IRB approval and that the study must be closed when human research activities have ceased. A Status Check-In report is due no later than three years after approval. Notices will be sent via the electronic system as described in Section 6.6.2.2. Failure of the Principal Investigator to submit the study status report after at least two notifications may be considered continuing noncompliance under Section 11.4.

10.4.1.5 Review Intervals for Ceded Studies

(Revised 8/11/19)
Studies ceded to an external IRB must comply with all applicable reporting requirements (see Section 2.5.4). For studies ceded on or after September 1, 2019, a Status Check-In report is due no later than three years after approval of the cede request.

A notice will be sent via the electronic system at one and two years after approval reminding the Principal Investigator of their reporting obligations and that the study must be closed when human research activities have ceased. Notices will be sent via the electronic system as described in Section 6.6.2.2. Failure of the Principal Investigator to submit the study status report after at least two notifications may be considered continuing noncompliance under Section 11.4.

10.4.2 Verification that No Unapproved Changes Have Occurred

(Revised 6/29/17)
One of the responsibilities of the Principal Investigator (see Section 6.6.1) is to ensure that IRB approval is obtained prior to making any change to the approved study plan, consent form, or study personnel unless the change is necessary for the safety of subjects. The IRB communicates responsibilities of the Principal Investigator as described in Section 11.2.3.

The IRB may receive information from a variety of sources that indicates that material changes may have occurred in a study prior to or without IRB approval, including Principal Investigator self-report, targeted audits, QA Reviews, research staff communications, subject complaints, and external monitoring reports. For amendments and progress reports, the IRB will document in the electronic system whether or not verification is needed from sources other than the investigator that no material changes have occurred since prior IRB review and there is no information that needs to be provided to current or former participants because it may affect their willingness to continue participation. If the IRB obtains information that unapproved changes may have occurred, the resulting investigation conducted as described in Section 11.4 will include evaluating whether it is appropriate to examine the Principal Investigator's other studies for instances where unapproved changes may have been made, or to seek verification from sources other than the Principal Investigator that no material changes have occurred. Further action will be taken as described in Section 11.4 as warranted, including requiring a Corrective and Preventative Action plan and suspension or termination of IRB approval.

10.5 Notification of Investigators

10.5.1 Prompt Notification

(Revised 8/30/16)
The IRB reports review decisions and board actions to the Principal Investigator via the electronic system within 5 working days of the decision or action.

10.5.2 Retention of Communications

(Revised 8/30/16)
Communications are retained in the electronic system as described in Section 4.4.

10.5.3 IRB Outcome Letters

(Revised 6/28/24)
The IRB approval letter includes the following information:

- Study name (with version number and/or date); and
- Notice of approval; and
- Review type; and
- Date of approval; and
- Expiration date or status check-in due date; and
- Funding source; and
- Study-specific determinations and findings:
  - Risk level (not greater than minimal risk or greater than minimal risk); and
  - Documentation of consent (written documentation or waiver); and
  - Use of PHI; and
  - Exclusion of limited- and non-readers (if applicable); and

  - Waiver/alteration of consent (if applicable); and
  - Inclusion of pregnant persons, fetuses, or neonates (if applicable); and
  - Child research category (if applicable); and
  - Parent permission and child assent requirements (if applicable); and
  - Requirements for re-consenting currently-enrolled subjects (if applicable); and
  - Investigational drug or device use (if applicable); and
  - Use of short-form oral presentation (if applicable); and
  - Inclusion of wards (if applicable); and
  - Prisoner research category (if applicable); and
  - Oversight of external sites (if applicable); and
- Amendment description (for approval of amendments); and
- Reminder of Principal Investigator responsibilities; and
- For studies with equivalent protections, notification that the Principal Investigator must report obtaining external funding to the IRB within 14 days of learning of the external funding.

When the study is approved, the electronic system sends a notification to the Principal Investigator and other members of the research team designated to receive notifications, with the approval letter as an attachment. Approval letters may be accessed in the electronic system at any time.

Other outcome letters provided via the electronic system include:
- Cede letters (see Section 10.2.3); and
- Exempt determination letters (see Section 10.2.4.4); and
- Not Human Subjects Research letters (see Section 10.2.5.4); and
- Not Engaged letters (see Section 10.2.6); and
- Internal Study Personnel Changes letters (see Section 10.2.7.1); and
- Closure letters (see Section 10.2.7.2); and
- Changes in contact information letters (see Section 10.2.7.3); and
- Disapproval letters (see Section 10.3.2.4); and
- Acknowledgement letters (see Section 10.3.2.5); and
- Board Action letters (see Section 10.3.2.6)

10.6 Investigator's Right to Appeal

(Revised 2/24/17)
If an IRB submission is disapproved, the reasons for disapproval are conveyed to the Principal Investigator via the electronic system. The Principal Investigator may make a formal request to the IRB to reconsider by responding to the disapproval letter within the electronic system. The Principal Investigator may request an opportunity to appear before the IRB to discuss the issues addressed in the disapproval.

10.7 Reporting by the HRPP of Unanticipated Problems, Serious or Continuing Noncompliance, and Suspension or Termination of Approval

(Revised 12/22/25)
The HRPP has reporting requirements when it is determined that one or more of the following has occurred:
- An Unanticipated Problem has occurred according to Section 10.2.1.5; or
- Serious or continuing noncompliance has occurred according to Section 11.4.3.5, 11.4.3.6, or 11.4.4.2; or
- Approval for a study is suspended or terminated according to Section 11.5; or
- An external IRB of record has determined that serious or continuing noncompliance or an unanticipated problem(s) has occurred at the Boston Medical Center or Boston University Medical Campus site; or
- An external IRB of record has suspended or terminated IRB approval at the Boston Medical Center or Boston University Medical Campus site.

The reporting requirements may be satisfied by a single report, or, if indicated, by an initial preliminary report followed by a final report when additional information is available. The report (single report or final report) describes the events and the actions taken by the HRPP.

The HRPP Director will report within 21 days of IRB determination of an Unanticipated Problem, serious or continuing noncompliance, or suspension or termination to, as applicable:

- The Principal Investigator; and
- The Principal Investigator's Department Chair/Section Chief; and
- The Principal Investigator's Dean; and
- The IOs; and
- The CEO of Boston Medical Center; and
- The IRB Director; and
- The IRB Chair; and
- The study sponsor and the Boston Medical Center or Boston University grants office (if the study has an external sponsor); and
- The Boston Medical Center Research Compliance Officer (if the study involves Boston Medical Center patients or resources).

The HRPP Director will also confirm that FDA receives a report if the study is a clinical investigation involving one or more products regulated by the FDA, and confirm that OHRP receives a report if the research is supported or conducted by the Department of Health and Human Services or by another Federal Agency that has adopted the Common Rule or if the study was initially approved prior to February 14, 2011. The HRPP Director will inform the IOs and the Boston Medical Center Research Compliance Officer of any report to the FDA or to OHRP.

10.8 Reporting by the HRPP to AAHRPP

(Revised 8/11/19)

The HRPP Director will report to AAHRPP within 48 hours of becoming aware of any of the following:

- Any negative actions taken by a government oversight office, including, but not limited to, OHRP determination letters, FDA Warning Letters, FDA 483 Inspection Reports with official action indicated, or FDA restrictions placed on the IRB or on Boston Medical Center or Boston University Medical Campus researchers; or
- Any litigation, arbitration, or settlements initiated related to human research protections; or
- Any press coverage (including but not limited to radio, TV, newspaper, online publications) of a negative nature regarding the Boston Medical Center and Boston University Medical Campus HRPP.

11 Compliance Oversight of Research

11.1 Responsibility for Research Oversight

(Revised 3/11/24)

The HRPP has the responsibility to evaluate and improve the conduct of research that it oversees (see Section 2.1). Consistent with this responsibility, the Research Quality Program within the HRPP may perform a targeted audit or a QA Review for the research activities of any investigator at Boston Medical Center or Boston University Medical Campus, even if another IRB is acting as the IRB of record (see Section 2.5), including international research (see Section 2.6). The HRPP Director has overall responsibility for all research oversight activities.

The HRPP has the authority to observe, or have a third party observe, the informed consent process of research over which it has oversight, and to verify that the study is being conducted in conformance with the approved study plan and with applicable federal and state laws, regulations, and guidance and HRPP and institutional policies. The HRPP may perform site visits, audits, or QA Reviews or use another party, either affiliated or not affiliated with either of the institutions, to verify information submitted to the IRB.

Other means of verification may include queries to the Principal Investigator or other members of the research staff, review of sponsors' monitoring reports and Data Safety Monitoring Board reports, review of medical records, and queries to subjects, family members, or clinicians. The HRPP may request signed copies of informed consents or other documents and may conduct interviews with screened or enrolled subjects as deemed necessary to verify research compliance.

The QA staff are the persons primarily responsible for conducting targeted audits and QA Reviews at Boston Medical Center and Boston University Medical Campus. The QA staff report administratively to the HRPP Assistant Director.

The HRPP Assistant Director maintains records relating to research oversight (including written materials concerning targeted audits and QA Reviews and written rationales/approvals by the HRPP Director for exceptions to research oversight policies and procedures).

11.2 Assistance in Maintaining Compliance

11.2.1 Education about Compliance

(Revised 2/24/17)
Educational programs provided for investigators and research staff are described in Section 6.4. The training emphasizes the importance of maintaining compliance with federal, state, and local laws, regulations, and guidance, and with institutional and HRPP policies and other responsibilities as described in Section 6.6.1.

11.2.2 Investigator Tools

(Revised 3/11/24)
The CRRO develops templated tools available to investigators and research staff on its website. These include templates to track adverse events, deviations, delegation of authority and responsibilities, location of essential documents, IRB submissions, participant identification, screening and enrollment, site visits, stored biospecimens, study participant termination, and both group and individual training logs. Additional tools include, but are not limited to, informed consent documentation, note to file template, phone call summary report, pregnancy testing documentation, eligibility criteria checklist, schedule of events, an adverse event form, a Standard Operating Procedure (SOP) template, and a study visit checklist.

Tools and guidance documents for conducting a self-assessment review are also made available to investigators and research staff on the CRRO website. These include an overview and instructions document that provides general information on self-assessments and their value for evaluating ongoing data integrity and participant safety, as well as templates for reviewing the overall study plan, participant eligibility, informed consent, and protocol adherence.

New tools are developed based on needs identified through QA Reviews, targeted audits, educational sessions, and researcher requests to assist in documentation and to assure the appropriate conduct of research and the reliability and validity of the data collected for research.

11.2.3 Communication of Investigator Responsibilities

(Revised 2/24/17)
Investigators are notified of their responsibilities as listed in Section 6.6.1 through the IRB website, through the attestation that is required for affixing their electronic signature to submissions in the electronic system, and through reminders in outcome letters.

11.3 Targeted Audits and QA Reviews

11.3.1 Goals of Targeted Audits

(Revised 3/11/24)

The goal of targeted audits is to investigate a situation in which a member of the HRPP has obtained information that indicates that there may be a risk to subject safety or to the validity of study data or that there may be noncompliance within the HRPP. In these cases, targeted audits are intended to evaluate the specific issue(s) that caused the need for the audit. Targeted audits may also be conducted to assess overall compliance in the targeted study or IRB process and in related studies or processes as warranted, even if there is no known indication or concern of noncompliance and/or risk to subjects.

11.3.2 Goals of QA Reviews

(Revised 3/11/24)
The goal of QA Reviews is to help investigators and research staff perform IRB-approved research in compliance with the applicable regulations, policies and guidance, in order to prevent adverse effects on the safety of participants or the reliability or validity of study data. Routine QA Reviews are intended to be educational and consultative in nature. The educational component involves providing the research staff with up-to-date information on best practices and connecting them to tools and education available through the HRPP. The consultative aspect is to find and help correct potential problems in study conduct, documentation, or process, including problems arising from IRB noncompliance.

The QA Review reports will typically identify the following categories of findings:

- Deviations: The Boston Medical Center and Boston University Medical Campus HRPP defines deviations in the two Sections bulleted below. The IRB of record, if different from the Boston Medical Center and Boston University Medical Campus IRB, may use different terms for deviations and may have different reporting requirements. If the IRB review is ceded, the QA review reports will outline the reporting requirements based upon the policies of the IRB of record and the Boston Medical Center and Boston University Medical Campus HRPP. In these instances, study teams will be directed to consult with the study sponsor (as applicable) and/or the IRB of record to determine if a major or minor deviation according to the Boston Medical Center and Boston University Medical Campus BMC/BUMC HRPP Policies and Procedures meets the reporting requirements under the policies for the IRB of record. An excerpt of the IRB of record's reporting policies will be included in an appendix of the QA report.
    - Major Deviations: see Section 6.6.5.2; and
    - Minor Deviations: see Section 6.6.5.3; and
- Important Findings: findings that do not require submission of a Reportable Event and New Information form as described in Section 7.4.5 but that do require some action by the Principal Investigator to address insufficiencies or other issues in study conduct and/or study documentation, such as submitting a Change Request and Amendment Form or other notification about the findings to the IRB, and/or Sponsor, and/or other Boston Medical Center or Boston University officials or committees, as applicable; and
- Best Practice recommendations: recommendations for study conduct and documentation usually based on ICH-GCP, often referencing tools and resources developed by the CRRO for study documentation (see Section 11.2.2).

11.3.3 Analysis of Patterns in Targeted Audits and QA Reviews

(Revised 3/11/24)
The HRPP Assistant Director will analyze results of both targeted audits and QA Reviews to identify any trends or patterns that suggest areas for improvements in education, training, communication strategies, policies, guidance, or research tools. This analysis will be done at least twice a year and is communicated to the HRPP Director as part of the HRPP quality improvement process described in Section 1.3.2.4 and to the Boston Medical Center Research Compliance Officer. To increase transparency of QA review findings as well as gain input from multiple stakeholders, the results from the analyses of the QA data are also reviewed by two multi-departmental groups: the QA Metrics Working Group and the QA Metrics Advisory Committee. The QA Metrics Advisory Committee acts in an advisory capacity in the development of new tools, trainings, and processes to benefit the BMC and BU Medical Campus research community and reviews recommendations developed by the QA Metrics Working Group.

11.3.4 Selection of Studies or IRB Processes for Targeted Auditing

(Revised 3/11/24)
A targeted audit occurs when a member of the HRPP has obtained information indicating a potential problem in a category of studies, in studies by a particular investigator, or in HRPP processes. The audit may be requested by vote of a convened IRB, by a Chair, by the IRB or HRPP Director, or by an IO. The audit may also be requested by an external IRB that is acting as the IRB of record for a study conducted by Boston Medical Center or Boston University Medical Campus investigators. A targeted audit may also be conducted to evaluate compliance with required processes, even if there are no known concerns that there is a potential problem. The request for the audit should include a description of the potential problem(s), any specific areas to focus on, and the time frame for scheduling the audit. The requestor of the audit is responsible for notifying any additional institutional individuals or offices if appropriate. A targeted audit may be requested for any study under the jurisdiction of the Boston Medical Center and Boston University Medical Campus HRPP, including those where an IRB other than the Boston Medical Center and Boston University Medical Campus IRB is acting as the IRB of record (see Section 2.5). An audit plan is developed by the QA staff in conjunction with the requestor(s) of the targeted audit to define the scope of the audit.

Situations that may warrant a targeted audit include, but are not limited to:

- A report of an Unanticipated Problem or major deviation where additional information is needed; or
- One or more studies conducted by an investigator who previously failed to comply with federal regulations or IRB policies; or
- Complex projects involving unusual levels or types of risk to subjects; or
- Studies conducted at an off campus site including international research; or
- Projects where continuing review information suggests that possible material changes occurred without IRB approval; or
- Projects where the pattern of adverse events or minor deviations reported at the time of continuing review suggests additional risks to subjects or others; or
- Studies involving the use of a drug, biologic, or device that is produced locally (at Boston Medical Center or Boston University); or
- Studies with Serious Adverse Events of major concern or a large number of Serious Adverse Events; or
- Studies where concerns have been identified by the Data Safety Monitoring Board, Data Monitoring Committee, or other study monitors; or
- Studies with subject complaints; or
- Studies with staff complaints; or
- Gene transfer research; or
- Investigator or research staff financial conflict of interest; or
- Institutional financial conflict of interest; or
- Information obtained during a QA Review indicating possible serious or continuing noncompliance; or
- Frequent submissions of requests for protocol exceptions; or
- Repeated submission of Corrective and Preventative Action plans that address the same or very similar problems; or
- Information indicating a potential problem with compliance by the IRB; or
- Review of specific HRPP processes to assess compliance with required standards.

11.3.5 Selection of Studies for QA Review

(Revised 3/11/24)
QA Reviews are most beneficial when performed soon after enrollment has begun but may be done at any time during the study, including after the study has closed. Any study conducted by Boston Medical Center and Boston University Medical Campus investigators or for which the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record may be chosen for review, including those

where an IRB other than the Boston Medical Center and Boston University Medical Campus IRB is acting as the IRB of record (see Section 2.5).

Studies are selected for QA Reviews from a report of newly-approved studies that is assessed by the HRPP Assistant Director (or QA staff working under the direction of the HRPP Assistant Director) approximately every two to three months. Recently-approved studies are prioritized for selection according to their potential for risk to subject safety or data integrity, based on having one or more of the following characteristics:

- Greater than minimal risk; or
- Investigator-initiated; or
- Interventional clinical trials; or
- First time Principal Investigators; or
- Studies where the Principal Investigator holds the IND or IDE; or
- Studies having a conflict of interest management plan; or
- Multi-site studies where the Principal Investigator has the responsibility for overseeing all sites; or
- Other characteristic(s) indicating that a QA Review would be appropriate.

In addition, studies where the Principal Investigator holds the IND or IDE will receive a QA Review once a year until the study is ended.

It is possible that individual Principal Investigators may have multiple QA Reviews ongoing at any given time if more than one of their studies meets the above prioritization characteristics in a given time frame.

Investigators may request that a QA Review be conducted on their studies at any time.

11.3.6 Scheduling of Audits and QA Reviews

(Revised 3/11/24)

The process for scheduling targeted audits is to notify the Principal Investigator, and if applicable, the individual responsible for the targeted HRPP component, that a targeted audit has been requested and communicate the time frame specified in the audit request. The date and time for the audit are scheduled with the Principal Investigator or responsible individual by the QA staff or HRPP Assistant Director either by email or by phone with email confirmation.

The process for scheduling QA Reviews is for the QA staff or HRPP Assistant Director to notify Principal Investigators by email that their study has been chosen for QA Review and to request that the Principal Investigator responds with an update on the study enrollment status. If no subjects have been enrolled, a follow-up email is sent to ask about enrollment status at a frequency based on the expected rate of enrollment as indicated by the study team. The QA Review is scheduled after at least one subject has been enrolled. The date and time for the QA Review is established with the Principal Investigator either by email or by phone with email confirmation.

11.3.7 Audit and QA Review Onsite and/or Remote Visit Procedures

(Revised 3/11/24)

QA reviews may take place in-person, remotely, or by a combination of methods (hybrid). QA staff have access to BMC Epic records. Remote access to study records, if needed, will be accomplished by secure exchange of documents and provision of access capabilities to the study's electronic databases, as well as HRPP documentation from the IRB electronic system. The Principal Investigator, another study investigator, or a research staff member should be available at the beginning of the QA review or the targeted audit for a brief discussion to help the QA staff understand study design, conduct, and documentation practices. Additional meetings, as needed, can be accomplished via in-person or remote communication methods. Method(s) will be selected based on specifics of the study, the study team, and the needs of the QA staff regarding elements of the study records that are needed to conduct the QA review or targeted audit. The PI or designee will provide access to all relevant research materials,

including documentation (source documents and study data) of adherence to the approved procedures, including:

- Study inclusion/exclusion criteria; and
- Informed consent process; and
- Informed consent documentation (usually all consent forms are reviewed); and
- Study procedures (a sample of subject records is selected for review); and
- Data Safety Monitoring Plan (including Adverse Event monitoring and reporting); and
- Staff training and qualifications; and
- Delegation of research staff responsibilities; and
- Confidentiality procedures and data storage processes.

The Principal Investigator is expected to be available to promptly answer questions by email or phone within a reasonable amount of time during and after the QA Review or targeted audit.

Other sources of information about aspects of research conduct may include reviewing or interviewing, as the need is identified:

- Relevant documents in electronic systems; and
- Incident reports; and
- Radiation safety or source documents; and
- Principal Investigators; and
- Study staff; and
- Research subjects; and
- Families of research subjects; and
- Research subject surrogates; and
- Investigational Pharmacy Services; and
- Other departments/divisions within Boston Medical Center or Boston University Medical Campus; and
- Sponsors.

For targeted audits of HRPP processes, in addition to interviewing HRPP staff and/or IRB members, the relevant HRPP documents are accessed through the electronic system and/or from other electronic or paper records.

On-site QA review activities typically take approximately one-half to a full day to complete. Targeted audits take a variable amount of time depending on the nature and complexity of the audit. If concerning issues are uncovered, the Principal Investigator or responsible individual is notified that additional time and further assessment is needed. In addition, when a Corrective and Preventative Action plan is required, a follow-up targeted audit may be scheduled to evaluate adherence to the plan.

For research conducted at non-local sites, including international research (see Section 2.6), the targeted audits or QA Reviews will generally be conducted remotely (as described above) rather than by on-site visits. If issues arise that can only be investigated by an onsite visit, options include travel by members of the Boston Medical Center and Boston University Medical Campus HRPP or arrangements with a local IRB or independent auditor.

11.3.8 Audit and QA Review Recommendations and Communication

(Revised 9/16/26)

Based on the findings and observations, one or more of the following recommendations may be made:

- No action is needed; or
- If the study is overseen by the Boston Medical Center and Boston University Medical Campus IRB or an IRB of record that requires such reporting, a summary of adverse events that are not Unanticipated Problems and a summary of minor deviations must be submitted to the IRB at the time of continuing review or status check-in; or

- If the study is overseen by the Boston Medical Center and Boston University Medical Campus IRB or an IRB of record that requires such reporting, one or more major deviations or reportable events has occurred, which the Principal Investigator must report according to the reporting requirements of the IRB; or
- One or more Unanticipated Problems have occurred, which the Principal Investigator must report to the Boston Medical Center and Boston University IRB using the Reportable Events and New Information form as soon as possible but no later than 7 calendar days of being made aware of an Unanticipated Problem, and in addition, must be reported to the IRB of record according to its requirements, if the Boston Medical Center and Boston University IRB is not the IRB of record; or
- One or more Important Findings (see Section 11.3.2) have been identified that necessitate some required action on the part of the Principal Investigator (such as an amendment to the study, obtaining clarification from the sponsor, or reporting a finding to other applicable Boston Medical Center or Boston University officials or committees); or
- If the study is overseen by the Boston Medical Center and Boston University Medical Campus IRB or an IRB of record that requires such reporting, one or more incidents involving privacy have occurred, which the Principal Investigator must report according to the reporting requirements of the IRB. Additionally, when the QA staff identifies a potential privacy incident, the QA staff will immediately notify the appropriate Privacy Officer(s) (see Sections 11.4.3.3 and 11.4.3.4), as well as Boston University Information, Services, and Technology (if the incident is a security issue and the investigator is conducting BU research and/or the privacy incident involves PHI from BU patients); or
- Urgent action is required to protect study subjects. If the QA staff determines that urgent action may be required, the QA staff will immediately notify the HRPP Assistant Director and/or the IRB Director, who follow up with the Principal Investigator, the IRB, the HRPP Director, the Boston Medical Center Research Compliance Officer, and the IOs, as appropriate, as well as with the IRB of record if the Boston Medical Center and Boston University Medical Campus IRB is not the IRB of record.

The QA staff prepares an Audit or QA Review Report summarizing the findings, observations, deviations, Important Findings, and recommendations. Questions or issues are addressed by communicating with the Principal Investigator or designated contact by email, by phone or virtual call with email confirmation, or in person. These queries must be answered promptly. If there is disagreement between the Principal Investigator and the QA staff regarding the classification of reportable finding(s) in the Audit or QA Review Report, the classification in the final Audit or QA Review Report will default to the determination made by the QA staff and HRPP Assistant Director. The Principal Investigator will be instructed to submit the reportable finding(s) to the IRB of record using the classification(s) in the final Audit or QA Review Report. The draft report is reviewed and edited by the HRPP Assistant Director and/or one of the other QA staff.

The reviewed Audit or QA Review Report is typically sent to the Principal Investigator or responsible individual approximately 1 month after the last onsite or remote visit. Turnaround times for the QA report may vary significantly by factors including, but not limited to, study complexity, findings, required follow-up activities, current workload, and study team responsiveness. As necessary, a QA staff member meets with the Principal Investigator and research staff before or after the report is completed to discuss observations and/or assist with the development of Corrective and Preventative Action plans. The QA Reviews do not require a formal response from the Principal Investigator, but the QA staff will follow-up to check on appropriate reporting by the PI. The QA staff will also follow-up to check that the Important Findings were addressed. For Audit Reports, the Principal Investigator or responsible individual is given 14 days to respond to the findings. The QA staff and/or the HRPP Assistant Director may make additional changes based on the response in finalizing the Audit Report, which will be sent to the Principal Investigator within 7 calendar days of receiving the response of the Principal Investigator or responsible individual. The final Audit Report is provided to the HRPP Director and the BMC Research Compliance Officer and to the individual(s) or Board requesting the report (see Section 11.3.10), who will then share the report with others as appropriate.

11.3.9 Follow Up of Recommendations

11.3.9.1 Follow Up of Recommended Submissions to the IRB

(Revised 9/16/26)
If submission of a summary of minor deviations at the time of continuing review or status check-in was recommended, for studies where the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record, the QA staff checks the Continuing Review or Status Check-In submission within 7 calendar days of the study expiration date or status check-in due date and takes the following actions:

- If the QA staff determines that the deviations were reported appropriately, no additional action is needed; or
- If the deviations have not been reported appropriately, and no Continuing Review or Status Check-In Report has been submitted by the study team, the QA team will remind the study team to submit the necessary form with the minor deviations identified in the QA review report; or
- If the Continuing Review or Status Check-In Report has been submitted, but the minor deviations have not been included or have not been accurately conveyed and the IRB has not approved the Continuing Review or Status Check-In Report, the QA team will ask the study team to provide the assigned IRB analyst with an accurate summary of the minor deviations; or
- If the Continuing Review or Status Check-In Report has been submitted, but the minor deviations have not been included or have not been accurately conveyed and the IRB has approved the Continuing Review or Status Check-In Report, then reporting requirements will depend on whether the minor deviations were reported at all or, if they were, how accurately they were reported to the IRB.
    - For example, if minor deviations were not reported at all or substantively mischaracterized, then this may need to be reported as a major deviation requiring submission of a Reportable Events and New Information form (see Section 6.6.5.2).

If submission of a Reportable Events and New Information form was recommended to report Unanticipated Problems and/or major deviations to the IRB of record, the HRPP Director provides a summary of the reportable finding(s) to the IRB of record.

If submission of a Reportable Events and New Information form was recommended to report Unanticipated Problems and/or major deviations to the Boston Medical Center and Boston University Medical Campus IRB, the QA staff checks the electronic system between 7 and 14 days after the date that the Principal Investigator was notified of the requirement to submit a Reportable Events and New Information form. If no form has been submitted, the QA staff notifies the Principal Investigator that the Reportable Events and New Information submission is overdue. The QA staff checks again 7 to 14 days after the second notification to the Principal Investigator, and if no Reportable Events and New Information form has been submitted, the QA staff sends one final notification to the study team before notifying the HRPP Assistant Director. The HRPP Assistant Director has the discretion to send one additional follow-up notification to the Principal Investigator or to immediately notify the IRB Director. If the HRPP Assistant Director sends a notification, and the required action is not taken within 2 calendar days of this final notification, the HRPP Assistant Director notifies the IRB Director. The IRB Director will treat the failure to submit a Reportable Events and New Information form or to make a requested change in an inaccurate form as noncompliance according to the process in Section 11.4.

If a submission or other action is recommended on the basis of an Important Finding, the QA staff will provide a timeframe in the report as to when that action should be completed. If the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record, the QA staff will check the electronic system within seven days of the stated timeframe to confirm that action has been taken on the Important Finding. Otherwise, the QA staff will query the Principal Investigator directly to confirm that action has been taken on the Important Finding. If the required action has not been taken, the QA staff notifies the Principal Investigator that the required action is overdue. The QA staff checks again 7 to 14 days after the second notification to the Principal Investigator, and if the required action has not been completed, the QA staff sends one final notification before notifying the HRPP Assistant Director. The

HRPP Assistant Director has the discretion to send one additional follow-up notification to the Principal Investigator or to immediately notify the IRB Director. If the HRPP Assistant Director sends a notification, and the required action is not taken within two days of this final notification, the HRPP Assistant Director notifies the IRB Director who will treat the incident as non-compliance according to the process in Section 11.4.

11.3.9.2 Follow Up of Corrective and Preventative Action Plans

(Revised 10/02/21)
Corrective and Preventative Action plans are submitted to and reviewed by the IRB as described in Section 11.4.3. The IRB may request a follow up onsite or remote visit to evaluate the effectiveness of the implementation of the Corrective and Preventative Action plan, based on the schedule for corrective actions contained in the Corrective and Preventative Action plan.

11.3.10 Reporting of Audit and QA Review Results

(Revised 7/20/26)
QA Reviews are provided to the Principal Investigator as described in Section 11.3.8 and to the HRPP Director and the Boston Medical Center Research Compliance Officer (if the study involves Boston Medical Center patients or resources). For targeted audits, the finalized Audit Report is also provided to the individuals or Board requesting the audit, who will share the report as appropriate, typically within seven days of receiving the response of the Principal Investigator or responsible individual to the Audit Report. Determinations made by the convened IRB in response to an Audit Report will be recorded in the minutes. If a different IRB is serving as the IRB of record (see Section 2.5), the finalized Audit Report will be sent to the IRB of record. For QA Review reports, any information from the QA Review that is considered potentially reportable under the policies and procedures of the IRB of record will be shared with the IRB of record. Upon request, the QA staff meets with the requesting individuals or Board.

11.3.11 External Audits by the Food and Drug Administration (FDA)

(Revised 10/02/21)
Investigators are expected to promptly notify the CRRO when they receive notifications that they will be audited by the FDA. The CRRO will notify the Boston Medical Center Research Compliance Officer (if the audited study involves recruiting subjects from Boston Medical Center), the HRPP Director, and the IRB Director. The Principal Investigator is responsible for notifying other appropriate entities within the institutions. The CRRO will be available to serve as a resource to the Principal Investigator in preparing for and responding to the audit.

11.4 Noncompliance

11.4.1 Identification of Noncompliance Incidents

(Revised 2/19/18)
Instances of potential noncompliance may be identified in various ways, including:

- The Principal Investigator, another study investigator, or a research staff member reports a major deviation by submitting a Reportable Events and New Information form; or
- The Principal Investigator summarizes minor deviations on a Progress Report at continuing review; or
- A targeted audit or a QA Review finds noncompliance initially or during follow up (noncompliance by investigators/research staff or by the IRB); or
- The HRPP receives a complaint from a subject or family member; or
- The HRPP receives a complaint from a study investigator or research staff member (whistleblower); or
- The HRPP receives a complaint about the IRB or other HRPP component from an investigator or research staff member; or
- The HRPP receives information about allegations of research noncompliance from any source; or

- During the course of routine IRB business, investigator or research staff noncompliance with IRB policies is noted; or
- During the course of routine IRB business, discrepancies are noted in the application of policies or regulations by the IRB.

When unapproved changes are made in a study to eliminate an apparent immediate hazard to subjects, the IRB will evaluate whether each change was consistent with ensuring the subjects' continued welfare, to determine whether the change from the approved protocol constitutes noncompliance.

11.4.2 Considerations for Classifying Noncompliance as Serious or Continuing

(Revised 2/24/17)
Noncompliance occurs when there is a failure on the part of an investigator, research staff member, or member of the HRPP to follow any applicable federal, state, or local law, regulation, or guidance; any HRPP or institutional policy; or any determination of the IRB, including the requirement to follow the approved study plan and use approved study documents.

Noncompliance by the investigator or research staff is considered serious when the noncompliance has the potential to substantially increase the risks to participants or to substantially decrease potential benefits (including by substantially impacting the validity of the study data). Conducting research activities in a greater than minimal risk study after approval has lapsed is considered serious noncompliance, unless the activities are limited to those in the best interests of the individual subjects (see Section 6.6.2.1.5.2). Noncompliance by the HRPP is considered serious when the HRPP materially fails to meet its fundamental obligations.

Noncompliance may be considered continuing when it is not corrected or when the noncompliance or a similar instance takes place after at least one notification to the responsible individuals that noncompliance has occurred.

11.4.3 Evaluation and Follow Up of Potential Researcher Noncompliance

11.4.3.1 Process for Evaluation and Follow Up

(Revised 6/30/16)
When information is received about potential noncompliance by researchers, the evaluation and follow up depends on how the information was uncovered and who initially receives the information. At any point, the individual or Board making the evaluation may request additional information or consult with other appropriate individuals before making a determination.

11.4.3.2 Potential Researcher Noncompliance Evaluated by QA Staff

(Revised 10/29/24)
When information about potential researcher noncompliance is received by QA staff during QA Reviews, they will make one of the following determinations:

- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident may constitute researcher noncompliance and requires further review. The QA staff will notify the Principal Investigator of the requirement to report deviations to the IRB.

When the QA staff receives information about potential noncompliance during a targeted audit, that information is included in the final Audit Report that is communicated to the individual or Board that requested the audit, in addition to any other recommended action (see Section 11.3.8).

11.4.3.3 Potential Researcher Noncompliance Evaluated by the IRB Staff

(Revised 7/20/26)

When information about potential researcher noncompliance is received by IRB staff during routine IRB operations, they will make one of the following determinations:

- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident constitutes researcher noncompliance. In this instance, they will make one of the following determinations:
    - If the IRB staff member is an Expediter (see Section 10.2.2.1), they may determine that the incident constitutes researcher noncompliance that is determined to be neither serious nor continuing; a Corrective and Preventative Action plan is required which will be evaluated by the Expediter; or
    - If the IRB staff is not an Expediter, or, if the IRB staff is an Expediter but determines that the incident constitutes researcher noncompliance that may be serious and/or continuing, the IRB staff will notify the IRB Director of the noncompliance.

In addition, if the report of potential researcher noncompliance involves a privacy incident, and is determined by the Expediter to constitute researcher noncompliance that is determined to be neither serious nor continuing, the Expediter will notify the appropriate Privacy Officer(s):

- The BMC Privacy Officer at privacyofficer@bmc.org, if the investigator is conducting BMC research and/or if the privacy incident involves PHI from BMC patients; and/or
- The BU Privacy Officer at HIPAA@bu.edu, if the investigator is conducting BU research and/or the privacy incident involves PHI from BU patients, as well as Boston University Information, Services, and Technology at ithelp@bu.edu, if the incident involves a security issue.

11.4.3.4 Potential Researcher Noncompliance Evaluated by the IRB Director or Chair

(Revised 7/20/26)

When the IRB Director or an IRB Chair receives information about potential researcher noncompliance, they make one of the following determinations:

- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident constitutes researcher noncompliance that is determined to be neither serious nor continuing; a Corrective and Preventative Action plan is required which will be evaluated by the IRB Director or Chair; or
- The incident constitutes researcher noncompliance that may be serious or continuing and is referred to the appropriate panel or to the Executive Board.

In addition, if the report of potential researcher noncompliance involves a privacy incident, the IRB Director or IRB Chair will notify the appropriate Privacy Officer(s):

- The BMC Privacy Officer at privacyofficer@bmc.org, if the investigator is conducting BMC research and/or if the privacy incident involves PHI from BMC patients; and/or
- The BU Privacy Officer at HIPAA@bu.edu, if the investigator is conducting BU research and/or the privacy incident involves PHI from BU patients, as well as Boston University Information, Services, and Technology at ithelp@bu.edu, if the incident involves a security issue..

11.4.3.5 Potential Researcher Noncompliance Evaluated by an IRB Panel

(Revised 2/24/17)

When an IRB panel considers information about potential researcher noncompliance at a convened meeting, the panel makes one of the following determinations:

- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident constitutes researcher noncompliance that is determined to be neither serious nor continuing; a Corrective and Preventative Action plan is required which will be evaluated by the panel or by the IRB Director or the panel Chair (as specified by the panel); or

- The incident constitutes researcher noncompliance that is appropriate for the panel to make the determination of serious or continuing noncompliance; a Corrective and Preventative Action plan is required which will be evaluated by the panel; or
- The incident constitutes researcher noncompliance that is appropriate for referral to the Executive Board.

A determination of serious or continuing noncompliance will be reported according to Section 11.4.5. In addition, the panel will make the following determinations:
- Whether any actions are needed to protect subjects; and
- Whether the study should be suspended or terminated (see Section 11.5); and
- Whether additional monitoring is required; and
- Whether the researcher(s) should be restricted from conducting study activities.

11.4.3.6 Potential Researcher Noncompliance Evaluated by the Executive Board

(Revised 3/21/17)
When the Executive Board considers information about potential noncompliance at a convened meeting, the Executive Board makes one of the following determinations:
- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident constitutes researcher noncompliance that is determined to be neither serious nor continuing; a Corrective and Preventative Action plan is required which will be evaluated by the Executive Board, an IRB panel, the IRB Director, or the Chair (as specified by the Executive Board); or
- The incident constitutes researcher noncompliance that is appropriate for the Executive Committee to make the determination of serious or continuing noncompliance; a Corrective and Preventative Action plan is required which will be evaluated by the Executive Board.

A determination of serious or continuing noncompliance will be reported according to Section 10.7. In addition, the Executive Board will make the following determinations:
- Whether any actions are needed to protect subjects; and
- Whether the study should be suspended or terminated (see Section 11.5); and
- Whether additional monitoring is required; and
- Whether the researcher(s) should be restricted from conducting human subjects research activities.

11.4.4 Evaluation and Follow Up of Potential Noncompliance by the HRPP

11.4.4.1 Process for Evaluation and Follow Up of HRPP Noncompliance

(Revised 2/24/17)
When information about potential noncompliance by the IRB or other component of the HRPP is obtained by a member of the HRPP, they will notify the HRPP Director, unless the HRPP Director is involved in the potential noncompliance, in which case, they will notify the IOs.

11.4.4.2 Potential HRPP Noncompliance Evaluated by the HRPP Director or IOs

(Revised 2/24/17)
When the HRPP Director or IOs consider information about potential HRPP noncompliance, they make one of the following determinations:
- The incident does not constitute noncompliance and the only additional action required is documentation as appropriate based on the source of the information; or
- The incident constitutes HRPP noncompliance that is determined to be neither serious nor continuing; a Corrective and Preventative Action plan is required which will be evaluated by the HPRR Director or IOs; or
- The incident constitutes HRPP noncompliance that is determined to be serious or continuing; a Corrective and Preventative Action plan is required which will be evaluated by the IOs.

A determination of serious or continuing noncompliance by the HRPP will be reported according to Section 10.7. In addition, the HRPP Director or IOs will make the following determinations:

- Whether any actions are needed to protect subjects or research integrity; and
- Whether the actions of any HRPP employees require further investigation; and
- Whether additional monitoring is required.

11.4.5 Follow-up of Serious or Continuing Noncompliance

(Revised 11/06/17)
When an IRB panel or the Executive Board makes determinations concerning serious or continuing noncompliance (see Sections 11.4.3.5, 11.4.3.6, and 11.4.4.2), the determinations are recorded in the minutes. Determinations of serious or continuing noncompliance are reported as described in Section 10.7.

11.5 Suspension or Termination of IRB Approval

(Revised 9/16/25)
The IRB may vote to restrict, suspend or terminate an investigator's privilege to conduct a research study, including investigators at external sites that are relying on the IRB (see Section 2.5), if the IRB makes a determination of serious or continuing noncompliance or if necessary for subject safety. Suspension of IRB approval is a temporary halt in IRB approval of some or all research activities. Termination is a permanent halt in IRB approval of all research activities. Suspension or termination can occur during the period for which IRB approval had already been given or at the time of continuing review (disapproval of the Progress Report). Any restriction, suspension, or termination of approval to conduct a research study, including a statement of the reasons for the action, is recorded in the electronic system, referenced in the minutes, and conveyed to the Principal Investigator through the electronic system within 7 calendar days of the IRB determination. The Principal Investigator may appeal this decision by submitting an appeal in writing to the Chair within 30 days, and may request an opportunity to appear before the IRB.

In considering the suspension or termination of approval, the IRB will obtain information from the Principal Investigator about whether any subjects are currently enrolled, and if so, whether there are any risks to the enrolled subjects from stopping the study.

If subjects are currently enrolled, the IRB will require the Principal Investigator to provide a plan describing how enrolled subjects will be notified of the study suspension or termination, including contact information for reporting any health or safety issues and any plans for follow-up monitoring. The IRB will evaluate whether any study interventions hold out the prospect of direct benefit to the subjects and whether withholding any interventions poses increased risk to the subjects. If so, the IRB will require the Principal Investigator to provide a plan describing how subjects will receive appropriate care during the period of suspension or following the cessation of the research. For example, the Principal Investigator may describe a plan for the subjects to continue to receive the research interventions and safety monitoring for a specified period of time, for the subjects to transfer to another institution engaged in the research, and/or for the subjects to transition to medical management outside of the research context.

Study suspension or termination is reported as described in Section 10.7.

11.6 Research Misconduct

(Revised 2/24/17)
Any allegations of research misconduct (serious ethical violations in proposing, performing, or reviewing research, or in reporting research results) that are received in the course of compliance investigations are referred to the Dean of the appropriate school as described in the Boston University Research Misconduct Policy or to the Boston Medical Center Office of the General Counsel as described in the Boston Medical Center Policies and Procedures Concerning Allegations of Misconduct in Scholarship and Research.

12 FDA and Other Federal Agency Requirements

12.1 Investigational New Drug (IND) Application

12.1.1 Requirements for Research Involving a Drug or Biological Agent

(Revised 12/24/18)
Any human subjects research involving a drug or biological agent, whether FDA approved or not, requires IRB approval. Studies that involve any drug, drug combination, or biological agent which has not been approved by the FDA for that use may require an Investigational New Drug application (IND) number from the FDA. The IND number and the name of the IND sponsor (holder of the IND) must be clearly indicated in the electronic system (see Section 7.2.2.8.1). When the investigator holds the IND, documentation from FDA of the IND is required, and the IRB does not accept a statement from the investigator that the FDA received the IND more than 30 days in the past.

Studies conducted under an IND will be reviewed at a convened IRB meeting, except that the IRB review for an individual patient IND may be carried out by a Chair or another IRB member designated by the Chair, if the IRB has documentation that the FDA has granted authorization under 21 CFR 56.105 to obtain concurrence by the IRB chairperson or by a designated IRB member, instead of at a convened IRB meeting, before the treatment use begins.

12.1.2 Research Involving Approved Drugs or Biological Agents

(Revised 6/22/21)
Studies involving the use of approved drugs or biological agents according to approved labeling are IND exempt if they meet all of the following criteria of 21 CFR 312.2(b)(1):

(i) The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug; and
(ii) If the drug that is undergoing investigation is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product; and
(iii) The investigation is conducted in compliance with the applicable requirements for institutional review and informed consent.

Approved drugs or biological agents being studied for an off label use such as an unapproved indication, for use in a different population, or used in a different dose or route than approved require one of the following:

- An IND number obtained from the FDA under 21 CFR 312 (including an individual patient IND under 21 CFR 312.310); or
- Documentation from the FDA stating that the drug or drug combination is IND Exempt; or
- IRB approval of the research as being IND Exempt under 21 CFR 312.2(b).

Studies involving off label use where the Principal Investigator requests that the IRB recognize an IND Exemption must meet all of the following criteria of 21 CFR 312.2(b)(1):

(i) The investigation is not intended to be reported to FDA as a well-controlled study in support of a new indication for use nor intended to be used to support any other significant change in the labeling for the drug; and
(ii) If the drug that is undergoing investigation is lawfully marketed as a prescription drug product, the investigation is not intended to support a significant change in the advertising for the product; and
(iii) The investigation does not involve a route of administration or dosage level or use in a patient population or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product; and
(iv) The investigation is conducted in compliance with the applicable requirements for institutional review and informed consent; and
(v) The investigation is conducted in compliance with the following requirements:

a) *Promotion of the drug.* A sponsor or investigator, or any person acting on behalf of a sponsor or investigator, shall not represent in a promotional context that the drug is safe or effective for the purposes for which it is under investigation or otherwise promote the drug; and
b) *Commercial distribution of the drug.* A sponsor or investigator shall not commercially distribute or test market the drug for the purposes for which it is under investigation; and
c) *Prolonging an investigation*. A sponsor shall not unduly prolong an investigation after finding that the results of the investigation appear to establish sufficient data to support a marketing application.

For studies involving off label use where the Principal Investigator requests that the IRB recognize an IND Exemption, the Principal Investigator must provide to the IRB, as part of the submission in the electronic system, sufficient documentation to support items (i), (ii), (iii), and (v) above (see Section 7.2.2.8.1). This information may include the results of previous studies, including animal and other human studies, discussion of risks, indications for populations who might be at increased risk, etc.

The IRB will approve an exemption under 21 CFR 312.2(b)(2) if the submission is for a study that uses an in vitro diagnostic biological product that involves one or more of blood grouping serum, reagent red blood cells, or anti-human globulin; the diagnostic test is intended to be used in a diagnostic procedure that confirms the diagnosis made by another, medically established, diagnostic product or procedure, and the diagnostic test is shipped in compliance with 21 CFR 312.160. The IRB will approve an exemption under 21 CFR 312.2(b)(5) if the study involves the use of a placebo and otherwise does not require an IND.

If the Principal Investigator requests that the IRB approve an IND Exemption, the IRB will determine whether the 21 CFR 312.2(b) criteria have been met. After review, the IRB may determine that the data presented do not substantiate an IND Exemption or the IRB may require that the Principal Investigator consult with the FDA and obtain a written determination about whether the study will require an IND.

Although the Principal Investigator makes a provisional determination that a 21 CFR 312.2(b) exemption applies, the IRB has regulatory responsibility to review and approve the conduct of a study under the 21 CFR 312.2(b) exemption. The IRB's determinations regarding IND Exemptions are documented in the electronic system if the study is reviewed via the expedited procedure, or in the IRB minutes if the study is reviewed at an IRB meeting. The Principal Investigator is informed of the finding in the outcome letter. The IRB may inform other departments within the institution, including the Boston University Office of Sponsored Research and Boston Medical Center Grants Administration, of its determinations.

12.1.3 Food Products and Supplements

(Revised 2/24/17)
Research that involves food products, food supplements or other products may require an IND if the research evaluates the effect on a disease. Where the IRB does not receive sufficient documentation that a product is being used as permitted by FDA regulations (only to affect the structure or any function of the body, not intended to be used for the diagnosis, cure, mitigation, treatment, or prevention of disease), the IRB may either consult the FDA or require a Principal Investigator to provide written documentation from the FDA about the regulatory status of the product being used in the study.

12.1.4 Use of Drugs and Biologic Products from the CDC Drug Service

(Revised 10/02/21)
Physicians at Boston Medical Center and BU Medical Campus who wish to use drugs and biologic products from the CDC Drug Service for patient treatment may apply according to the instructions provided at the CDC website. The CDC utilizes FDA's IND status as a mechanism to provide these drugs in the United States. The CDC IRB determines that use of Drug Service products does not constitute human subjects research because they are provided for treatment purposes only (45 CFR 46.102(l)). Therefore, IRB review for compliance with 45 CFR 46 is not needed.

The CDC IRB is willing to serve as the central IRB for review of the IND protocol to help reduce the administrative burden on local IRBs and allow timely use of the formulary products for treatment. Due to

the volume of hospitals that may be involved in administration of Drug Service products, it is not feasible for the CDC IRB to enter into formal IRB authorization agreements. In order to facilitate timely treatment, if the CDC agrees to provide a CDC Drug Service product to a physician at Boston Medial Center or Boston University Medical Campus for a clinical situation approved under the CDC IND protocol, no IRB submission to the Boston Medical Center and Boston University Medical Campus IRB is required. The Boston Medical Center and Boston University Medical Campus IRB will use the CDC's IRB approval of the protocol to meet FDA's regulatory requirements for IRB review, without a formal IRB authorization agreement. CDC does not require local IRB approval or any documentation of local IRB approval.

In requesting, obtaining, and administering CDC Drug Service Products, the treating physician is serving as a site investigator and is required to comply with the requirements of the IND and with all CDC requirements for receipt of product under the CDC IND protocol, including, but not limited to, serious adverse event reporting and completion of all patient report forms. A statement of consent must be obtained before administration under the IND protocol is initiated. A consent form, approved by CDC's IRB, is provided with the product. A copy of this form must be given to the patient, a copy should be maintained in the patient's file, and a third copy should be returned to CDC upon completion of therapy.

Physicians at Boston Medical Center and Boston University Medical Campus who wish to use these products in clinical situations that are not approved under the CDC IND protocol or that wish to make any alterations in dosing schedule or dosage form must submit a separate IND application to the FDA directly, and follow the policies and procedures described in the following Sections, depending on whether the use qualifies as emergency or non-emergency use:

- Emergency Use: Sections 7.2.2.2, 7.2.2.21, 12.3.1 , and 12.3.3
- Individual patient IND: Sections 7.2.2.2, 7.2.2.4, 7.2.2.5, 7.2.2.8.1, 7.2.2.22 and 12.1.1

12.2 Investigational Device Exemption (IDE)

12.2.1 Requirements for Research Involving a Device

(Revised 10/31/16)
Any human subjects research involving a device, whether FDA approved or not, requires IRB approval. Studies that involve any device which has not been approved by the FDA for that use may require an Investigational Device Exemption (IDE) from the FDA. The IDE number and the name of the IDE sponsor (holder of the IDE) must be clearly indicated in the electronic system (see Section 7.2.2.8.2).

12.2.2 Significant and Non-Significant Risk Devices

(Revised 10/31/16)
Significant vs. Non-significant Risk Devices: A significant risk (SR) device means an investigational device that presents a potential for serious risk to the health, safety, or welfare of a subject and

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

12.2.3 Investigational Device Exemption (IDE) Requirements

(Revised 12/24/18)
Studies using devices which are not approved by the FDA or which are being studied for "off-label use" require one of the following:

- An IDE approved by the FDA under 21 CFR 812.30; or
- Documentation stating that the device is exempt from the requirement to have an IDE under 21 CFR 812.2(c):
  - The FDA has approved/cleared the device for the use described in the study; or
  - The device is not a transitional device, was in commercial distribution immediately before May

28, 1976, and will be used or investigated in accordance with the indications in labeling in effect at that time; or
    - The device is not a transitional device, was introduced into commercial distribution on or after May 28, 1976, and will be used or investigated in accordance with the indications in the labeling FDA reviewed under subpart E of part 807 in determining substantial equivalence (clearance under FDA 510(k)); or
    - The device is undergoing consumer preference testing, testing of a modification, or testing of a combination of two or more devices in commercial distribution, and the testing is not for the purpose of determining safety or effectiveness and does not put participants at risk; or
    - The device is a custom device as defined in 21 CFR 812.3(b), and the device is being used to determine safety or effectiveness for commercial distribution; or
- An abbreviated IDE based on IRB approval under 21 CFR 812.2(b)(1); or
- An IDE exemption for an in vitro diagnostic device based on IRB approval under 21 CFR 812.2(c)(3).

12.2.4 Abbreviated IDE Requirements

12.2.4.1 Request for an Abbreviated IDE Determination

(Revised 2/24/17)
If the Principal Investigator is requesting that the IRB make an abbreviated IDE determination under 812.2(b), then as part of the submission, it is the responsibility of the Principal Investigator to provide to the IRB sufficient documentation to support the claim that the device, AS BEING USED IN A PARTICULAR STUDY, is a non-significant risk device (see Section 7.2.2.8.2). This information may include the results of previous studies, including animal and other human studies, discussion of risks, indications for populations who might be at increased risk, any information as to how the device has been altered, etc.

During a convened meeting the IRB will determine whether the 812.2(b) criteria have been met and the study is a non-significant risk device study. If the IRB determines that the 812.2(b) criteria have been met, the device is considered to have an “abbreviated IDE” and the Principal Investigator is considered to be the sponsor with responsibilities as described in Section 12.2.4.2 unless some other company or individual is the regulatory sponsor.

12.2.4.2 Responsibilities of Sponsor-Investigators with an Abbreviated IDE

(Revised 9/1520)
The Principal Investigator of a study that is requesting an abbreviated IDE for use of a non-significant risk device must attest to the following responsibilities of sponsor-investigators with abbreviated IDEs (see 21 CFR 812(b)):

1) The device is not a banned device under 21 CFR 895
2) The device will be labeled in accordance with 21 CFR 812.5 and 21 CFR 801.1
3) The study will be monitored in accordance with 21 CFR 812.46
4) The Principal Investigator will maintain records in accordance with 21 CFR 812.140(b) (4) and (5)
5) The Principal Investigator will report as required by 21 CFR 812.150(b) (1) through (3) and (5) through (10)
6) The Principal Investigator will ensure that participating investigators will obtain and document consent from each of their subjects
7) The Principal Investigator will ensure that participating investigators will maintain the records required by 21 CFR 812.140(a)(3)(i)
8) The Principal Investigator will ensure that participating investigators report as required by 21 CFR 812.150(a) (1), (2), (5), and (7)
9) The study will comply with the prohibitions in 21 CFR 812.7 against promotion and other practices

The regulations referenced in requirements 1) through 9) are addressed in the remainder of this section.

1) The device is not a banned device under 21 CFR 895

   21 CFR 895 Subpart B lists banned devices and should be consulted to verify that the device is not a banned device.

2) The device will be labeled in accordance with 21 CFR 812.5 and 21 CFR 801.1

21 CFR 812.5 Labeling of investigational devices

(a) *Contents.* An investigational device or its immediate package shall bear a label with the following information: the name and place of business of the manufacturer, packer, or distributor (in accordance with 21 CFR 801.1), the quantity of contents, if appropriate, and the following statement: “CAUTION—Investigational device. Limited by Federal (or United States) law to investigational use.” The label or other labeling shall describe all relevant contraindications, hazards, adverse effects, interfering substances or devices, warnings, and precautions.

(b) *Prohibitions.* The labeling of an investigational device shall not bear any statement that is false or misleading in any particular and shall not represent that the device is safe or effective for the purposes for which it is being investigated.

21 CFR 801.1 Medical devices; name and place of business of manufacturer, packer or distributor.

(a) The label of a device in package form shall specify conspicuously the name and place of business of the manufacturer, packer, or distributor.

(b) The requirement for declaration of the name of the manufacturer, packer, or distributor shall be deemed to be satisfied, in the case of a corporation, only by the actual corporate name which may be preceded or followed by the name of the particular division of the corporation. Abbreviations for “Company,” “Incorporated,” etc., may be used and “The” may be omitted. In the case of an individual, partnership, or association, the name under which the business is conducted shall be used.

(c) Where a device is not manufactured by the person whose name appears on the label, the name shall be qualified by a phrase that reveals the connection such person has with such device; such as, “Manufactured for ___”, “Distributed by _____”, or any other wording that expresses the facts.

(d) The statement of the place of business shall include the street address, city, State, and Zip Code; however, the street address may be omitted if it is shown in a current city directory or telephone directory. The requirement for inclusion of the ZIP Code shall apply only to consumer commodity labels developed or revised after the effective date of this section. In the case of nonconsumer packages, the ZIP Code shall appear on either the label or the labeling (including the invoice).

(e) If a person manufactures, packs, or distributes a device at a place other than their principal place of business, the label may state the principal place of business in lieu of the actual place where such device was manufactured or packed or is to be distributed, unless such statement would be misleading.

3) The study will be monitored in accordance with 21 CFR 812.46

21 CFR 812.46 Monitoring Investigations

(a) *Securing compliance.* A sponsor who discovers that an investigator is not complying with the signed agreement, the investigational plan, the requirements of this part or other applicable FDA regulations, or any conditions of approval imposed by the reviewing IRB or FDA shall promptly either secure compliance, or discontinue shipments of the device to the investigator and terminate the investigator's participation in the investigation. A sponsor shall also require such an investigator to dispose of or return the device, unless this action would jeopardize the rights, safety, or welfare of a subject.

(b) *Unanticipated adverse device effects.*

(1) A sponsor shall immediately conduct an evaluation of any unanticipated adverse device effect. *Unanticipated adverse device effect* means 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.

(2) A sponsor who determines that an unanticipated adverse device effect presents an unreasonable risk to subjects shall terminate all investigations or parts of investigations presenting that risk as soon as possible. Termination shall occur not later than 5 working days after the sponsor makes this determination and not later than 15 working days after the sponsor first received notice of the effect.

(c) *Resumption of terminated studies.* If the device is a significant risk device, a sponsor may not resume a terminated investigation without IRB and FDA approval. If the device is not a significant risk device, a sponsor may not resume a terminated investigation without IRB approval and, if the investigation was terminated under paragraph (b)(2) of this section, FDA approval.

4) The Principal Investigator will maintain records in accordance with 21 CFR 812.140(b) (4) and (5)

21 CFR 812.140 Records

(b) *Sponsor records.* A sponsor shall maintain the following accurate, complete, and current records relating to an investigation:

(4) For each investigation subject to abbreviated IDE requirements, the records described in paragraph (b)(5) of this section and the following records, consolidated in one location and available for FDA inspection and copying:

(i) The name and intended use of the device and the objectives of the investigation;

(ii) A brief explanation of why the device is not a significant risk device;

(iii) The name and address of each investigator;

(iv) The name and address of each IRB that has reviewed the investigation;

(v) A statement of the extent to which the good manufacturing practice regulation in 21 CFR 820 will be followed in manufacturing the device; and

(vi) Any other information required by FDA.

(5) Records concerning adverse device effects (whether anticipated or unanticipated) and complaints

5) The Principal Investigator will report as required by 21 CFR 812.150(b) (1) through (3) and (5) through (10)

21 CFR 812.150 Reports

(b) *Sponsor reports.* A sponsor shall prepare and submit the following complete, accurate, and timely reports:

(1) *Unanticipated adverse device effects.* A sponsor who conducts an evaluation of an unanticipated adverse device effect under 21 CFR 812.46(b) [defined in 2. above in this section] shall report the results of such evaluation to FDA and to all reviewing IRB's and participating investigators within 10 working days after the sponsor first receives notice of the effect. Thereafter the sponsor shall submit such additional reports concerning the effect as FDA requests.

(2) *Withdrawal of IRB approval.* A sponsor shall notify FDA and all reviewing IRB's and participating investigators of any withdrawal of approval of an investigation or a part of an investigation by a reviewing IRB within 5 working days after receipt of the withdrawal of approval.

(3) *Withdrawal of FDA approval.* A sponsor shall notify all reviewing IRB's and participating investigators of any withdrawal of FDA approval of the investigation, and shall do so within 5 working days after receipt of notice of the withdrawal of approval.

(4) *Not Applicable for abbreviated IDEs*

(5) *Progress reports.* At regular intervals, and at least yearly, a sponsor shall submit progress reports to all reviewing IRB's. In the case of a significant risk device, a sponsor shall also submit progress reports to FDA. A sponsor of a treatment IDE shall submit semi-annual progress reports to all reviewing IRB's and FDA in accordance with §812.36(f) and annual reports in accordance with this section.

(6) *Recall and device disposition.* A sponsor shall notify FDA and all reviewing IRB's of any request that an investigator return, repair, or otherwise dispose of any units of a device. Such notice shall occur within 30 working days after the request is made and shall state why the request was made.
(7) *Final report.* In the case of a significant risk device, the sponsor shall notify FDA within 30 working days of the completion or termination of the investigation and shall submit a final report to FDA and all reviewing the IRB's and participating investigators within 6 months after completion or termination. In the case of a device that is not a significant risk device, the sponsor shall submit a final report to all reviewing IRB's within 6 months after termination or completion.
(8) *Informed consent.* A sponsor shall submit to FDA a copy of any report by an investigator under 21 CFR 812.150(a)(5) [listed in 6. below in this section] of use of a device without obtaining informed consent, within 5 working days of receipt of notice of such use.
(9) *Significant risk device determinations.* If an IRB determines that a device is a significant risk device, and the sponsor had proposed that the IRB consider the device not to be a significant risk device, the sponsor shall submit to FDA a report of the IRB's determination within 5 working days after the sponsor first learns of the IRB's determination.
(10) *Other.* A sponsor shall, upon request by a reviewing IRB or FDA, provide accurate, complete, and current information about any aspect of the investigation.

6) The Principal Investigator will ensure that participating investigators will obtain and document consent from each of their subjects. This is part of the Principal Investigator's general oversight of all participating investigators.

7) The Principal Investigator will ensure that participating investigators will maintain the records required by 21 CFR 812.140(a)(3)(i)

21 CFR 812.140 Records
(a) *Investigator records*. A participating investigator shall maintain the following accurate, complete, and current records relating to the investigator's participation in an investigation:
(3) Records of each subject's case history and exposure to the device. Case histories include the case report forms and supporting data including, for example, signed and dated consent forms and medical records including, for example, progress notes of the physician, the individual's hospital chart(s), and the nurses' notes. Such records shall include:
(i) Documents evidencing informed consent and, for any use of a device by the investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent. The case history for each individual shall document that informed consent was obtained prior to participation in the study.

8) The Principal Investigator will ensure that participating investigators report as required by 21 CFR 812.150(a) (1), (2), (5), and (7)

21 CFR 812.150 Reports
(a) *Investigator reports.* An investigator shall prepare and submit the following complete, accurate, and timely reports:
(1) *Unanticipated adverse device effects.* An investigator shall submit to the sponsor and to the reviewing IRB a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but in no event later than 10 working days after the investigator first learns of the effect.
(2) *Withdrawal of IRB approval.* An investigator shall report to the sponsor, within 5 working days, a withdrawal of approval by the reviewing IRB of the investigator's part of an investigation.
(3) *Not Applicable for abbreviated IDEs*
(4) *Not Applicable for abbreviated IDEs*

(5) *Informed consent.* If an investigator uses a device without obtaining informed consent, the investigator shall report such use to the sponsor and the reviewing IRB within 5 working days after the use occurs.
(6) *Not Applicable for abbreviated IDEs*
(7) *Other.* An investigator shall, upon request by a reviewing IRB or FDA, provide accurate, complete, and current information about any aspect of the investigation.

9) The study will comply with the prohibitions in 21 CFR 812.7 against promotion and other practices

21 CFR 812.7 Prohibition of promotion and other practices.
A sponsor, investigator, or any person acting for or on behalf of a sponsor or investigator shall not:
(a) Promote or test market an investigational device, until after FDA has approved the device for commercial distribution.
(b) Commercialize an investigational device by charging the subjects or investigators for a device a price larger than that necessary to recover costs of manufacture, research, development, and handling.
(c) Unduly prolong an investigation. If data developed by the investigation indicate in the case of a class III device that premarket approval cannot be justified or in the case of a class II device that it will not comply with an applicable performance standard or an amendment to that standard, the sponsor shall promptly terminate the investigation.
(d) Represent that an investigational device is safe or effective for the purposes for which it is being investigated.

12.2.5 IDE Exemptions for In Vitro Diagnostic Devices

(Revised 2/24/17)
If the Principal Investigator requests that the IRB make an IDE exemption for an in vitro diagnostic device determination under 812.2(c)(3), then as part of the submission, the Principal Investigator will confirm that the device and testing comply with the exemption requirements for labeling and use (see Section 7.2.2.8.2).

In evaluating whether the device or sampling procedure is noninvasive, a noninvasive device or procedure (see 21 CFR 812.3(k)) is considered one that does not, by design or intention penetrate or pierce the skin or mucous membranes of the body, the ocular cavity, or the urethra or enter the ear beyond the external auditory canal, the nose beyond the nares, the mouth beyond the pharynx, the anal canal beyond the rectum, or the vagina beyond the cervical os. Blood sampling that involves simple venipuncture is considered noninvasive, and the use of surplus samples of body fluids or tissues that are left over from samples taken for noninvestigational purposes is also considered noninvasive.

12.2.6 Communication of Device Determinations

(Revised 6/22/21)
If the IRB determines that an IDE is required, the IRB will notify the Principal Investigator and the sponsor. The Principal Investigator must then consult the FDA for a determination as to the device's regulatory status.

The IRB's determinations regarding non-significant risk device studies and abbreviated IDE requirements are documented in the IRB minutes. The IRB's determinations regarding IDE exemptions are documented in the electronic system if the study is reviewed via the expedited procedure, or in the IRB minutes if the study is reviewed at an IRB meeting. The Principal Investigator is informed of the IRB's findings in the IRB outcome letter. The Principal Investigator should provide the sponsor a copy of the letter. The IRB may inform other departments within the institution, including the Boston University Office of Sponsored Research and Boston Medical Center Grants Administration, of its determinations.

12.3 Emergency Use of Drugs, Biological Agents, and Devices

12.3.1 Emergency Use of Drugs and Biological Agents

(Revised 6/29/17)
The emergency use of an investigational drug or biological agent with a patient 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 may occur if it is the medical judgment of a physician that it is in the patient's best interest. Any subsequent use of this test article is subject to IRB review and approval.

The physician should notify the IRB Director prior to this emergency use if possible, but this notification is not to be construed as IRB approval. The requirements for informed consent in Section 12.3.3 must be followed.

The emergency use of an investigational drug or biological agent is considered a clinical investigation, the patient is considered a subject, and the FDA may require data from an emergency use to be reported in a marketing application. DHHS regulations do not permit data obtained from patients treated by emergency use to be classified as human subjects research, nor permit the outcome of such care to be included in any report of a research activity subject to DHHS regulations.

The physician must submit a report to the IRB of this emergency use using the electronic system (see Section 7.2.2.21) within 5 working days of the treatment.

12.3.2 Emergency Use of Medical Devices

(Revised 6/29/17)
The emergency use of an investigational medical device may occur if the patient is in a life-threatening condition that needs immediate treatment; there is no generally acceptable alternative for treating the patient and there is reason to believe that the medical device will provide a benefit; and because of the immediate need to use the device, there is no time to obtain IRB approval. The physician should notify the IRB Director if possible prior to use of the device. These notifications are not to be construed as IRB approval. The requirements for informed consent in Section 12.3.3 must be followed. This patient is not considered a research subject and data from this patient may not be included in any report of the research. The physician must submit a written report of this emergency use to the IRB within 5 working days (see Section 7.2.2.21). Any subsequent use of this device is subject to IRB review and approval.

A medical device eligible for the above procedure includes a device that does not yet have an IDE/HDE, or if the proposed use is not approved under an existing IDE/HDE, or if the physician or institution is not approved to use this device under an existing IDE/HDE.

12.3.3 Informed Consent for Emergency Use

(Revised 6/29/17)
The patient or legally-authorized representative must sign a consent form for emergency use of an investigational drug, biologic, or device, unless:

a) The human subject is confronted by a life-threatening situation necessitating the use of the test article; and
b) Informed consent cannot be obtained from the subject because of an inability to communicate with, or obtain legally effective consent from, the subject; and
c) Time is not sufficient to obtain consent from the subject's legal representative; and
d) There is available no alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the subject.

The treating physician using the investigational drug, biologic, or device must certify in writing that each of the above conditions is satisfied before the use of the investigational drug, biologic, or device. An independent physician who is not otherwise participating in any clinical investigation of the investigational drug, biologic, or device must also certify in writing that each of the above conditions is satisfied, either before the use or, if the treating physician certifies in writing the opinion that immediate use of the test

article is required to preserve the life of the subject, and time is not sufficient to obtain an independent determination in advance of the use, no more than 5 working days after the use.

12.3.4 Processing of Reports for Emergency Use

(Revised 6/29/17)
Reports of emergency use will be evaluated by IRB staff. If the use complied with HRPP policies and FDA requirements, a written acknowledgment will be sent to the treating physician. If the use did not comply with HRPP polices or FDA requirements, the procedures in Section 11.4 for noncompliance will be followed.

12.4 Humanitarian Device Exemptions

12.4.1 Regulatory Background for Humanitarian Device Exemptions (HDEs)

(Revised 8/11/19)
The purpose of the HDE law and its implementing regulations (21 CFR 814.100 -126) “is, to the extent consistent with the protection of the public health and safety and with ethical standards, to encourage the discovery and use of devices intended to benefit patients in the treatment or diagnosis of diseases or conditions that affect or are manifested in not more than 8,000 individuals in the United States per year.” [21 CFR 814.100(b)] The law prescribes a method that permits a manufacturer to lawfully market a device without meeting the efficacy standards generally required for FDA pre-market approval of devices. After a manufacturer applies for an HDE, meets the regulatory requirements, and obtains FDA approval of Humanitarian Use Device (HUD) status, the HUD may be used in humans. However, the law permits the use of HUDs only in facilities that have a local IRB and provided that the IRB approves the HUD’s use in the facility.

12.4.2 Application of 21 C.F.R. §56.111 Approval Criteria

(Revised 2/24/17)
The IRB performs initial and continuing review of each application for use of a HUD. For initial approval for use of a HUD, review by the convened IRB is required; however, continuing review may take place under an expedited procedure.

The IRB follows the FDA Guidance that the FDA does not interpret the HDE law to require IRB review and approval for each individual use of the HUD. The IRB requires that a request for approval for the use of a HUD be submitted via the electronic system (see Section 7.2.2.23) and be reviewed by the convened IRB and that progress reports be submitted at least annually. The progress report must indicate how many patients have been treated with the device and any adverse events or patient complaints related to the device. In addition, the IRB may specify limitations on the use of the device based upon one or more measures of disease progression, prior use and failure of any alternative treatment modalities, reporting requirements to the IRB or IRB Chair, appropriate follow-up precautions and evaluations, or any other criteria it determines to be appropriate.

12.4.3 Informed Consent for Humanitarian Use Devices (HUDs)

(Revised 10/31/16)
Since the HDE law does not require informed consent and because the FDA has determined that the humanitarian device exemption provides for temporary marketing approval, HUD use does not constitute human subjects research and the IRB is not required to review any consent process that may be required in the normal hospital clinical context.

Importantly, it should be noted that if the manufacturer wants to collect safety and effectiveness data in support of a pre-market approval (PMA) application, the informed consent requirements under Section 8.2 would apply.

12.4.4 Emergency Use of a HUD

(Revised 12/14/17)
In an emergency, physicians can use a HUD prior to IRB approval if they determine that IRB approval "can not be obtained in time to prevent serious harm or death to a patient." 21 U.S.C. §360j (m) (4) (B). In such a circumstance, the physician shall, after the use of the device, notify the chairperson of the IRB of such use. Such notification shall include:

- the identification of the patient involved; and
- the date on which the device was used; and
- the reason for the use.

12.4.5 Off-Label Use of a HUD

(Revised 12/14/17)
After the IRB has approved the use of a HUD under an HDE, the HUD may be used outside its approved indication (off-label use), in an emergency (where time did not permit submission to the IRB) or if a physician determines that this is the best treatment option for the patient's condition. The physician must report off-label use in an emergency situation according to Section 12.4.4. The physician must submit a request for non-emergency off-label use as protocol exception to the IRB-approved HUD application (see Section 7.4.2). The IRB Chair will evaluate submissions for off-label use of HUDs (see Section 10.2.2.4.2.2), considering that the FDA has made a determination of safety and probable benefit for use of the HUD only within its approved indication(s) and considering the potential need for additional reasonable patient protection measures, such as devising schedules to monitor the patient, taking into consideration the patient's specific needs and the limited information available about the risks and benefits of the device. The IRB Chair may ask for additional information or changes, and may refer the submission to the convened IRB. The physician must notify the HDE holder prior to the off-label use and submit a follow-up report on the patient's condition to the HDE holder.

12.4.6 User Facility Adverse Event Reporting Requirements for HUDs

(Revised 3/28/16)
The IRB has to report to either or both the FDA and the manufacturer.

Death Reported Directly to FDA: "Whenever a user facility receives or otherwise becomes aware of information, from any source, that reasonably suggests that a device has or may have caused or contributed to the death of a patient of the facility, the facility shall as soon as practicable, but not later than 10 work days after becoming aware of the information" it must report both the FDA and the manufacturer. 21 C.F.R. §803.30(a) (1)

Serious Injury Reported to Manufacturer: "Reports of serious injury. Whenever a user facility receives or otherwise becomes aware of information, from any source, that reasonably suggests that a device has or may have caused or contributed to a serious injury to a patient of the facility, the facility shall, as soon as practicable but not later than 10 work days after becoming aware of the information" must report to the manufacturer. 21 C.F.R. §803.30(a) (2) If the manufacturer is unknown, the report shall be made directly to FDA**.**

12.4.7 Requirements for Using Electronic Records and Electronic Signatures in Drug or Device Research

(Revised 4/21/23)
The FDA regulations at 21 CFR Part 11 set forth the criteria under which FDA considers electronic records, electronic signatures, and handwritten signatures executed to electronic records to be trustworthy, reliable, and generally equivalent to paper records and handwritten signatures executed on paper. Part 11 applies to records in electronic form that are created, modified, maintained, archived, retrieved, or transmitted under any records requirements set forth in FDA regulations. 21 CFR Part 11 also applies to electronic records submitted to FDA under the Federal Food, Drug, and Cosmetic Act (the

Act) and the Public Health Service Act (the PHS Act), even if such records are not specifically identified in FDA regulations.

An FDA 21 CFR Part 11 compliant system requires two components: 1) technical software specifications, procedures, and documentation as described in the 21 CFR Part 11 regulations, and 2) essential processes, such as procedures, training, validation, and documentation that are put in place at the project level, by the clinical investigation team, to meet 21 CFR Part 11 requirements.

For FDA-regulated drug or device studies conducted by the Principal Investigator at Boston Medical Center or Boston University Medical Campus under an IND or IDE, it is the responsibility of the Principal Investigator to ensure compliance with 21 CFR Part 11 requirements for electronic records and electronic signatures if the study uses an electronic system managed by Boston Medical Center or Boston University for documentation of electronic records and electronic signatures. This responsibility also extends to studies that are not conducted under an IND or IDE, but that involve study data that will be submitted to FDA. Noncompliance with 21 CFR Part 11 requirements for electronic records and electronic signatures is evaluated as described in Section 11.4.

Information on 21 CFR Part 11 requirements and guidance on available electronic systems at BMC and BU Medical Campus that meet these requirements is available on the IRB website.

12.5 Research Using Education Records Subject to the Family Educational Rights and Privacy Act

(Revised 9/28/16)

The Family Educational Rights and Privacy Act (FERPA) establishes requirements for the protection of student education records (see 34 CFR 99). Research involving student education records, regardless of the source of funding, must meet FERPA requirements in addition to the criteria for approval under Sections 10.1.1.1 and 9.2. Education records are records that are directly related to a student and maintained by an educational agency or institution, or by a party acting for the agency or institution.

A researcher may obtain student education records from an educational agency or institution under one of the following four conditions:

- The information is not personally identifiable (all identifiers have been removed, including students' names and other direct personal identifiers, such as social security number or student number; indirect identifiers, such as the name of parents or other family member; address and personal characteristics or other information that would make the students' identity easily traceable; date and place of birth and mother's maiden name; biometric records, including one or more measurable biological or behavioral characteristics that can be used for automated recognition of an individual, including fingerprints, retina and iris patterns, voiceprints, DNA sequence, facial characteristics, and handwriting; and other information that, alone or in combination, is linked or linkable to a specific student that would allow a reasonable person in the school community, who does not have personal knowledge of the relevant circumstances, to identify the student with reasonable certainty.); or
- The information is limited to directory information [name; address; telephone listing; electronic mail address; photograph; date and place of birth; major field of study; grade level; enrollment status (e.g., undergraduate or graduate, full-time or part-time); dates of attendance (the overall period of time in which a student was in attendance, not specific daily records of attendance); participation in officially recognized activities and sports; weight and height of members of athletic teams; degrees, honors and awards received; and the most recent educational agency or institution attended]; or
- The parent or eligible student (a student who is 18 or older or is attending a post-secondary institution) has provided signed and dated (including via electronic signature) written consent for the release of the education records that includes:
    - The records that may be disclosed; and
    - The purpose of the disclosure; and
    - The party or class of parties to whom the records may be disclosed; and
    - That the parent or eligible student may request a copy of the records that are disclosed; or

- The researcher is conducting the study for or on behalf of the educational agency or institution in order to develop, validate, or administer predictive tests, administer student aid programs, or improve instruction and the educational agency or institution enters into a written agreement with the researcher's organization that:
  - Specifies the purpose, scope, and duration of the study or studies and the information to be disclosed; and
  - Requires the researcher's organization to use personally identifiable information from education records only to meet the purpose or purposes of the study as stated in the written agreement; and
  - Requires the researcher's organization to conduct the study in a manner that does not permit personal identification of parents and students by anyone other than representatives of the organization with legitimate interests; and
  - Requires the researcher's organization to destroy or return to the educational agency or institution all personally identifiable information when the information is no longer needed for the purposes for which the study was conducted and specifies the time period in which the information must be returned or destroyed

12.6 Research Subject to Department of Education Requirements

(Revised 2/24/17)

When a research project involving surveys, analyses, or evaluations, involving physical examinations or screenings, or involving instructional material used in a research or experimentation program is conducted by a Principal Investigator at Boston Medical Center or Boston University Medical Campus in an educational institution that receives funding from the Department of Education (regardless of the source of funding for the research project itself), the Principal Investigator must confirm that that educational institution is in compliance with the requirements of the Protection of Pupil Rights Amendment (20 U.S.C. section 1232h):

(a) Inspection of instructional materials by parents or guardians
All instructional materials, including teacher's manuals, films, tapes, or other supplementary material which will be used in connection with any survey, analysis, or evaluation as part of any applicable program shall be available for inspection by the parents or guardians of the children.

(b) Limits on survey, analysis, or evaluations
No student shall be required, as part of any applicable program, to submit to a survey, analysis, or evaluation that reveals information concerning—
(1) political affiliations or beliefs of the student or the student's parent;
(2) mental or psychological problems of the student or the student's family;
(3) sex behavior or attitudes;
(4) illegal, anti-social, self-incriminating, or demeaning behavior;
(5) critical appraisals of other individuals with whom respondents have close family relationships;
(6) legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers;
(7) religious practices, affiliations, or beliefs of the student or student's parent; or
(8) income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program),
without the prior consent of the student (if the student is an adult or emancipated minor), or in the case of an unemancipated minor, without the prior written consent of the parent.

(c) Development of local policies concerning student privacy, parental access to information, and administration of certain physical examinations to minors. Note that these rights transfer from the parents to a student who is 18 years old or an emancipated minor under State law.
(A) Development and adoption of local policies
A local educational agency that receives funds under any applicable program shall develop and adopt policies, in consultation with parents, regarding the following:
(B) Surveys
(i) The right of a parent of a student to inspect, upon the request of the parent, a survey created by a third party before the survey is administered or distributed by a school to a student; and

(ii) any applicable procedures for granting a request by a parent for reasonable access to such survey within a reasonable period of time after the request is received.

(C) Arrangements to protect student privacy that are provided by the agency in the event of the administration or distribution of a survey to a student containing one or more of the following items (including the right of a parent of a student to inspect, upon the request of the parent, any survey containing one or more of such items):
(i) Political affiliations or beliefs of the student or the student's parent.
(ii) Mental or psychological problems of the student or the student's family.
(iii) Sex behavior or attitudes.
(iv) Illegal, anti-social, self-incriminating, or demeaning behavior.
(v) Critical appraisals of other individuals with whom respondents have close family relationships.
(vi) Legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers.
(vii) Religious practices, affiliations, or beliefs of the student or the student's parent.
(viii) Income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program).

(D) Instructional material
(i) The right of a parent of a student to inspect, upon the request of the parent, any instructional material used as part of the educational curriculum for the student; and
(ii) any applicable procedures for granting a request by a parent for reasonable access to instructional material within a reasonable period of time after the request is received.

(E) The administration of physical examinations or screenings that the school or agency may administer to a student.

(F) The collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose), including arrangements to protect student privacy that are provided by the agency in the event of such collection, disclosure, or use.

(G) Personal information
(iii) The right of a parent of a student to inspect, upon the request of the parent, any instrument used in the collection of personal information under subparagraph (E) before the instrument is administered or distributed to a student; and
(iv) any applicable procedures for granting a request by a parent for reasonable access to such instrument within a reasonable period of time after the request is received.

(9) Parental notification

(A) Notification of policies
The policies developed by a local educational agency under paragraph (1) shall provide for reasonable notice of the adoption or continued use of such policies directly to the parents of students enrolled in schools served by that agency. At a minimum, the agency shall—
(i) provide such notice at least annually, at the beginning of the school year, and within a reasonable period of time after any substantive change in such policies; and
(ii) offer an opportunity for the parent (and for purposes of an activity described in subparagraph (C)(i), in the case of a student of an appropriate age, the student) to opt the student out of participation in an activity described in subparagraph (C).

(B) Notification of specific events
The local educational agency shall directly notify the parent of a student, at least annually at the beginning of the school year, of the specific or approximate dates during the school year when activities described in subparagraph (C) are scheduled, or expected to be scheduled.

(C) Activities requiring notification
The following activities require notification under this paragraph:
(i) Activities involving the collection, disclosure, or use of personal information collected from students for the purpose of marketing or for selling that information (or otherwise providing that information to others for that purpose).
(ii) The administration of any survey containing one or more items described in clauses (i) through (viii) of paragraph (1)(B).

(iii) Any nonemergency, invasive physical examination (any medical examination that involves the exposure of private body parts, or any act during such examination that includes incision, insertion, or injection into the body) or screening that is—
(I) required as a condition of attendance;
(II) administered by the school and scheduled by the school in advance; and
(III) not necessary to protect the immediate health and safety of the student, or of other students.

12.7 Research Subject to Department of Justice Requirements

12.7.1 Research Conducted in the Federal Bureau of Prisons

(Revised 6/29/17)
Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.

For research conducted within the Federal Bureau of Prisons, when submitting a research proposal, the applicant shall provide the following information:

- A summary statement, which includes:
  - Names and current affiliations of the researchers.
  - Title of the study.
  - Purpose of the study.
  - Location of the study.
  - Methods to be employed.
  - Anticipated results.
  - Duration of the study.
  - Number of participants (staff or inmates) required and amount of time required from each.
  - Indication of risk or discomfort involved as a result of participation.
- A comprehensive statement, which includes:
  - Review of related literature.
  - Detailed description of the research method.
  - Significance of anticipated results and their contribution to the advancement of knowledge.
  - Specific resources required from the Bureau of Prisons.
  - Description of all possible risks, discomforts, and benefits to individual participants or a class of participants, and a discussion of the likelihood that the risks and discomforts will actually occur.
  - Description of steps taken to minimize any risks.
- Description of physical or administrative procedures to be followed to:
  - Ensure the security of any individually identifiable data that are being collected for the study.
  - Destroy research records or remove individual identifiers from those records when the research has been completed.
- Description of any anticipated effects of the research study on organizational programs and operations.
- Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.

Research that is funded by the Department of Justice and conducted in the Federal Bureau of Prisons must meet the following requirements (see 28 CFR 512) in addition to the criteria for approval under Section 10.1.1.1 (see 28 CFR 46):

- The research is reviewed by the Bureau of Prisons Research Review Board; and
- The rights, health, and human dignity of individuals involved are respected; and
- The project has an adequate research design and will contribute to the advancement of knowledge about corrections; and
- The project does not involve medical experimentation, cosmetic research, or pharmaceutical testing; and
- Risks to subjects are minimized; and

- Risks to subjects within any one institution are equitable; and
- The written informed consent statement to be given to each participant before commencing a research project requiring participation by staff or inmates contains the following information:
  - Identification of the Principal Investigator(s); and
  - Objectives of the research project; and
  - Procedures to be followed in the conduct of research; and
  - Purpose of each procedure; and
  - Anticipated uses of the results of the research; and
  - A statement of benefits reasonably to be expected; and
  - A declaration concerning discomfort and risk, including a description of anticipated discomfort and risk; and
  - A statement that participation is completely voluntary and that the participant may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable); and
  - A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, a researcher may not guarantee confidentiality when the subject indicates an intent to commit future criminal conduct or harm himself/herself or someone else, or, if the subject is an inmate, indicates an intent to leave the facility without authorization; and
  - A statement that participation in the research project will have no effect on the inmate participant's release date or parole eligibility; and
  - An offer to answer questions about the research project; and
  - Appropriate additional information as needed to describe adequately the nature and risks of the research; and
- Written documentation is either:
  - Obtained by having the subject sign the statement of informed consent prior to initiating the research activity.
  - Waived if the researcher has demonstrated that the only link to the subject's identity is the signed statement of informed consent or that there is significantly more risk to the subject if the statement is signed.
- No incentives are offered to help persuade inmate subjects to participate. However, soft drinks and snacks to be consumed at the test setting may be offered. Reasonable accommodations such as nominal monetary recompense for time and effort may be offered to non-confined research subjects who are both no longer in Bureau of Prisons custody and participating in authorized research being conducted by Bureau employees or contractors.
- The researcher has academic preparation or experience in the area of study of the proposed research.
- The researcher assumes responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor to the research.
- Except as noted in the informed consent statement to the subject, the researcher will not provide research information which identifies a subject to any person without that subject's prior written consent to release the information. For example, research information identifiable to a particular individual cannot be admitted as evidence or used for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertains.
- The researcher will adhere to the applicable provisions of the Privacy Act of 1974 and regulations pursuant to this Act.
- The research design is compatible with both the operation of prison facilities and protection of human subjects.
- The researcher will observe the rules of the institution or office in which the research is conducted.
- Any researcher who is a non-employee of Bureau of Prisons has signed a statement in which the researcher agrees to adhere to the provisions of 28 CFR 512.
- Except for computerized data records maintained at an official Department of Justice site, records which contain nondisclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system.

- If a non-employee of Bureau of Prisons will receive records in a form not individually identifiable, advance adequate written assurance that the record will be used solely as a statistical research or reporting record has been provided.
- If the researcher is conducting a study of special interest to the Office of Research and Evaluation (ORE) but the study is not a joint project involving ORE, the researcher may be asked to provide ORE with the computerized research data, not identifiable to individual participants, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.

For research conducted within the Federal Bureau of Prisons

- At least once a year, the researcher shall provide the ORE chief with a report on the progress of the research.
- At least 12 working days before any report of findings is to be released, the researcher shall distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The researcher shall include an abstract in the report of findings.
- In any publication of results, the researcher shall acknowledge the Bureau's participation in the research project.
- The researcher shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.
- Prior to submitting for publication the results of a research project conducted under this subpart, the researcher shall provide two copies of the material, for informational purposes only, to the ORE Chief, Central Office, Bureau of Prisons.

12.7.2 Research Supported by the National Institute of Justice

(Revised 6/29/17)

Research funded by the National Institute of Justice must meet the following requirements in addition to the criteria for approval under Section 10.1.1.1 (see 28 CFR 46):

- A privacy certificate approved by the National Institute of Justice specific to this research has been obtained (see http://www.nij.gov/funding/humansubjects/pages/welcome.aspx); and
- The Principal Investigator has provided assurance that the Principal Investigator and all research staff understand the privacy certificate guidelines under 28 CFR 22.23; and
- The consent form confidentiality section includes:
  - The name(s) of the funding agency(ies); and
  - A statement that the subject's private, identifiable information will be kept confidential and will only be used for research and statistical purposes; and
  - A statement that the identifiable data collected is immune from legal process because the researcher submitted a Privacy Certificate; and
  - A statement that the subject will be notified if due to sample size or some unique feature of the data, the confidentiality of the subject's identity cannot be maintained; and
  - A statement that the subject will be asked to provide prior written consent before the investigator discloses any information, including information about child abuse, except that confidentiality will be broken if the participant reports information about immediate risk of harm to subjects or others. The written consent will cover what information would be disclosed, under what circumstances, and to whom, and any potential risks of the disclosure.

For research funded by the National Institute of Justice, a copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.

12.8 Research Subject to Environmental Protection Agency Requirements

(Revised 6/28/24)

Research that is supported by the US Environmental Protection Agency or that is conducted with the intention of submitting the results to the US Environmental Protection Agency must meet the following requirements in addition to the criteria for approval under Section 10.1.1.1 (see 40 CFR 26):

- The research does not involve intentional exposure of pregnant persons, nursing women, or children to any substance; and
- The research meets the Common Rule criteria for approval for observational research involving pregnant persons and children (Subparts C and D) or the criteria are not applicable; and
- Observational research involving children that is greater than minimal risk but presents the prospect of direct benefit to the individual participants is approvable only if the IRB finds and documents that:
  - The intervention or procedure holds out the prospect of direct benefit to the individual participant or is likely to contribute to the participant's well-being; and
  - The risk is justified by the anticipated benefit to the participants; and
  - The relation of the anticipated benefit to the risk is at least as favorable to the participants as that presented by available alternative approaches; and
  - Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth in Section 40 CFR 26.406; and
- The Principal Investigator has provided assurance that the research will not begin without final review and approval by the EPA Human Subjects Research Review official.

12.9 Research Subject to Department of Energy Requirements

(Revised 9/15/20)

Research that is supported by the US Department of Energy must meet the following requirements (see DOE Order 443.1C) in addition to the criteria for approval under Section 10.1.1.1 (see 10 CFR 745):

- Department of Energy requirements for the protection of Personally Identifiable Information (PII), defined as any information collected or maintained by the Department about an individual, including but not limited to, education, financial transactions, medical history and criminal or employment history, and information that can be used to distinguish or trace an individual's identity, such as name, Social Security number, date and place of birth, mother's maiden name, biometric data, and including any other personal information that is linked or linkable to a specific individual:
  - keeping PII confidential; and
  - releasing PII only under a procedure approved by the responsible IRB and DOE; and
  - using PII only for purposes of the IRB-approved project; and handling and marking documents containing PII as "containing PII" or "containing Protected Health Information (PHI)"; and
  - establishing and documenting reasonable administrative, technical, and physical safeguards to prevent unauthorized use or disclosure of PII and PHI; and
  - making no further use or disclosure of the PII except when approved by the responsible IRB(s) and DOE, where applicable, and then only:
    - in an emergency affecting the health or safety of any individual; or
    - for use in another research project under these same conditions and with DOE written authorization; or
    - for disclosure to a person authorized by the DOE program office for the purpose of an audit related to the project; or
    - when required by law; and
  - protecting PII stored on removable media using encryption procedures that are compliant with Federal standards (FIPS-140-2 certified); and
  - using FIPS 140-2 certified encryption that meet the current DOE password requirements cited in DOE Guide 205.3-1; and
  - sending removable media containing PII by express overnight service with signature and tracking capability and sending hard copy documents double wrapped via express overnight service; and
  - encrypting data files containing PII that are being sent by e-mail with FIPS 140-2 certified encryption products; and
  - sending passwords to encrypted files separately from the files; and

  - using FIPS 140-2 certified encryption methods for websites established for the submission of information that includes PII; and
  - using 2-factor authentication for log-on access for remote systems.
- Department of Energy requirements for protected classes of human subjects:
  - DOE federal and DOE contractor employees are considered vulnerable subjects when participating in research and additional care must be taken to ensure their participation is truly voluntary (e.g., by ensuring they do not report to members of the research team) and that data collected about them is kept confidential.
- Department of Energy reporting requirements:
  - The Human Subjects Protection Manager must be notified in writing prior to initiation of the human subjects research portion of a new project, even if it meets the definition of exempt research as outlined in 10 CFR Part 745.104, that involves:
    - an institution without an established IRB; or
    - a foreign country; or
    - a potential for significant controversy (e.g., negative press or reaction from stakeholder or oversight groups); or
    - research subjects in a protected class (prisoners, children, individuals with impaired decision making, or DOE federal or DOE contractor employees as human subjects, who may be more vulnerable to coercion and undue influence to participate) that is outside of the reviewing IRB's typical range/scope; or
    - the generation or use of classified information.
  - The Principal Investigator must report to the IRB within 48 hours of learning about the following events, and the HRPP Director must report these events to the Department of Energy within 48 hours:
    - Any significant adverse events, unanticipated problems, and complaints about the research; and
    - Any noncompliance with the Department of Energy Human Subjects Protection program procedures or other requirements; and
  - The HRPP Director must immediately (interpreted as within 48 hours) report to the Department of Energy:
    - Suspension or termination of IRB approval
    - A suspected or confirmed data breach involving PII in printed or electronic form. Such a report must be made to: 1) the DOE funding office Program Manager, or, if funded by an outside organization, the Program Manager at that organization; 2) the applicable DOE site or central IRB. If the DOE Program Manager and/or IRB is unreachable, the Principal Investigator is responsible for immediately notifying the DOE Joint Cybersecurity Coordination Center (JC3) (1-866-941-2472).

The periodic self-assessment process described in Section 1.3.2 will ensure the compliance of Boston Medical Center and Boston University Medical Campus with the HRPP procedures and other requirements, in accordance with Department of Energy requirements.

12.10 Research Subject to Department of Defense (DoD) Requirements

12.10.1 General Requirements for DoD Supported Research

(Revised 6/29/17)
Research that is supported by any component of the Department of Defense (DoD) must meet all requirements of that component in addition to the criteria for approval in Section 10.1.1.1. Support by a DoD component can consist of funding through a contract, grant, or cooperative agreement; use of DoD property, facilities or assets; or inclusion of DoD personnel as subjects (through intervention or interaction or through access to identifiable information).

The Boston Medical Center and Boston University Medical Campus HRPP complies with the following laws, regulations, and guidance when conducting, reviewing, approving, overseeing, supporting, or managing DoD-supported research with human subjects:

- Title 32 Code of Federal Regulations Part 219 (32 CFR 219), Department of Defense Regulations, "Protection of Human Subjects" (Note – this is the same as 45 CFR 46, the "Common Rule")
- Title 45 Code of Federal Regulations Part 46, (45 CFR 46) Department of Health and Human Services Regulations, "Protection of Human Subjects," Subparts B, C, and D as made applicable by DoDD 3216.02
- Title 21 Code of Federal Regulations 50, 56, 312, and 812, FDA Regulations
- DoD Directive (DoDD) 3216.02, "Protection of Human Subjects and Adherence to Ethical Standards in DoD-supported Research"
- Title 10 United States Code Section 980 (10 USC 980), "Limitation on Use of Humans as Experimental Subjects"
- DoDD 3210.7, "Research Integrity and Misconduct"
- DoD Instruction (DoDI) 6200.02, "Application of Food and Drug Administration (FDA) Rules to Department of Defense Force Health Protection Programs"
- DoD Instruction (DoDI) 1100.12, "DoD Surveys"
- SECNAVISNT 3900.39D

Non-exempt classified research will be conducted following the requirements of DoDD 3216.02, Section 13: "Classified Research Involving Human Subjects."

12.10.2 DoD-Specific Education Requirements

(Revised 9/28/16)
All members of the Boston Medical Center and Boston University Medical Campus HRPP complete initial and continuing educational training commensurate with their duties and responsibilities in reviewing, approving, and overseeing human subjects research, as described in Sections 3.5 and 4.1.

All those involved in the conduct of human subjects research fulfill the educational training requirements described in Sections 6.2.3 and 6.4. It is the responsibility of the Principal Investigator to provide the IRB with a plan to comply with any additional training requirements of the DoD component supporting the research.

12.10.3 DoD-Specific Minimal Risk and Exemption Requirements

(Revised 6/29/17)
For DoD-supported research, the definition of minimal risk based on the phrase "ordinarily encountered in daily life or during the performance of routine physical or physiological examination or tests" shall not be interpreted to include the inherent risks certain categories of human subjects face in their everyday life. For example, the risks imposed in research involving human subjects focused on a special population should not be evaluated against the inherent risks encountered in their work environment (e.g., emergency responder, pilot, soldier in a combat zone) or having a medical condition (e.g., frequent medical tests or constant pain.)

The determination that research qualifies as exempt is performed by a member of the IRB staff, not the Principal Investigators, as described in Section 10.2.4.

12.10.4 DoD-Specific Scientific Review

(Revised 6/29/17)
The IRB will approve research (initial submissions, amendments, and progress reports) if the criteria for approval in Section 10.1.1.1 are satisfied, including that the research design is scientifically appropriate and the degree of risk to the human subjects is justifiable. The IRB may rely on outside experts to provide an evaluation of the scientific merit.

12.10.5 Additional Protections for Military Research Subjects

(Revised 6/29/17)

Where research subjects include members of the military (both military personnel and DoD civilians), the following additional protections are required to minimize undue influence to agree to participate:

- Service members/civilians shall follow their command/organizational policies regarding the requirement to obtain permission to participate in research involving human subjects.
- Superiors are prohibited from influencing the decisions of their subordinates regarding participation as subjects in research involving human subjects and shall not be present at any human subject recruitment sessions or during the consent process.
- For research involving service members as human subjects that has been determined to be greater than minimal risk and when recruitment occurs in a group setting, the IRB shall appoint an ombudsman. The ombudsman shall not be associated in any way to the research and shall be present during the recruitment in order to monitor that the voluntary involvement or recruitment of the Service members is clearly and adequately stressed and that the information provided about the research is clear, adequate, and accurate. The ombudsman may also be the research monitor (see Section 12.10.8). For research involving service members as human subjects, that has been determined to be NO greater than minimal risk and when recruitment occurs in a group setting, and for research involving DoD civilians, the IRB shall determine when it is appropriate to appoint an ombudsman for the purposes described in this paragraph. The decision to require the appointment of an ombudsman should be based in part on the human subject population, the consent process, and the recruitment strategy.

When research involves U.S. military personnel, officers and senior non-commissioned officers must have a separate opportunity to participate.

12.10.6 DoD-Specific Requirements for Research-Related Injury

(Revised 9/28/16)
Consent for DoD-supported research that is greater than minimal risk must include information about available compensation or medical treatments if a research-related injury occurs (see Section 8.2.1). For research subject to Department of the Navy (DON) requirements, every project involving greater than minimal risk shall include an arrangement for emergency treatment and necessary follow-up of any research-related injury. The IRB will determine whether research involving minimal risk also might include a similar arrangement for research-related injury.

12.10.7 DoD-Specific Requirements for Reporting

(Revised 6/29/17)
HRPP Director will report within 30 days of the incident the following to the human research protection officer of the sponsoring DoD component when research involving a DoD-supported research project is involved:

- Notification by any federal department or agency or national organization of a for-cause investigation; and
- Unanticipated problems (see Section 10.2.1.5); and
- Suspensions or terminations of IRB approval (see Section 11.5); and
- Serious or continuing noncompliance (see Section 11.4.5); and
- Change of reviewing IRB.

In addition, for research subject to Department of the Navy (DON) requirements, the HRPP Director will report the following to the DON HRPP Office:

- The initiation and results of investigations into allegations of noncompliance; and
- Serious adverse events; and
- Audits, investigations, or inspections of research; and
- Audits, investigations, or inspections of the Boston Medical Center and Boston University Medical Campus HRPP conducted by outside entities; and
- Significant communication between institutions conducting research and other federal departments and agencies regarding compliance and oversight; and

- All restrictions, suspensions, or terminations of the Boston Medical Center or the Boston University Medical Campus assurances.

12.10.8 DoD-Specific Requirements for a Medical Monitor

(Revised 9/15/20)
For DoD-supported research, prior to April 15, 2020, a named independent research monitor was required for greater than minimal risk research and was optional for minimal risk research. As of April 15, 2020, a research monitor is no longer required by the DoD for DoD-supported research, regardless of risk level.

Under the DoD rules prior to April 15, 2020, there may be more than one research monitor (e.g., if different skills or experiences are necessary). The monitor may be an ombudsman (see Section 12.10.5) or a member of the data safety monitoring board (see Section 10.1.1.2.3). The research monitors must have expertise consonant with the nature of risk(s) identified within the research protocol, and be independent of the research team. The duties of the research monitor shall be determined on the basis of specific risks or concerns about the research. The research monitor may perform oversight functions and report to the IRB or a designated official. The research monitor may discuss the research protocol with the investigators, interview human subjects, and consult with others outside of the study about the research. The research monitor must have authority to stop a research protocol in progress, remove individual human subjects from a research protocol, and take whatever steps are necessary to protect the safety and well-being of human subjects until the IRB can assess the monitor's report. Research monitors must have the responsibility to promptly report their observations and findings to the IRB or other designated official. The IRB will approve a written summary of the monitors' duties, authorities, and responsibilities. The IRB will communicate with research monitors to confirm their duties, authorities, and responsibilities.

Principal Investigators with protocols approved prior to April 15, 2020 that include a research monitor may submit an amendment to remove the independent research monitor and describe an alternative method for monitoring the study. Until the amendment requesting the removal of the research monitor receives IRB approval, the Principal Investigator must comply with the research monitor's roles and responsibilities as delineated in the protocol.

12.10.9 DoD-Specific Requirements for International Research

(Revised 9/28/16)
The IRB will work with the sponsoring DoD component as necessary to resolve any conflicts with applicable international laws and requirements and to ensure that the cultural sensitivities in the setting where the research will take place are considered (see Section 2.6). For international research subject to Department of the Navy requirements with human subjects who are not U.S. citizens or DoD personnel, permission of the host country and an ethics review by the host country, or local Naval IRB with host country representation, are required.

12.10.10 DoD-Specific Requirements for Protection of Vulnerable Populations

(Revised 6/28/24)
For DoD-supported research, the IRB will apply the protections in Section 9, with the following additions:

- For Section 9.2 (Children), all active duty service members and all reserve component members in a Federal duty status as defined by DOD are considered to be adults. When service members, students at service academies, or trainees are under 18 years of age, the IRB shall carefully consider the recruitment process and the necessity to include such members as human subjects
- For Section 9.3 (Prisoners):
  - Review by the expedited procedure is not permitted
  - The permitted categories of research are those listed in Section 9.3.6 , except that epidemiologic research is allowable when the research describes the prevalence or incidence of a disease by identifying all cases or studies potential risk factor association for a disease, the

research presents no more than minimal risk, and the research presents no more than an inconvenience to the participant.
    - An additional permitted category of research is research qualifying for category (2) in Section 10.2.4.2.1
    - If a previously-enrolled subject becomes incarcerated:
        - The Principal Investigator will notify the IRB and include their opinion about whether it is in the best interests of the subject to continue to participate.
        - The IRB Chair will either agree to allow the subject to continue to participate or require that all interventions (including obtaining identifiable private information) must cease.
        - The IRB, at a convened meeting that includes input from the prisoner representative, will evaluate whether or not to allow the subject to continue in the research, considering whether the subject can meaningfully consent to continue to participate and whether the conditions of incarceration allow continued participation. The research does not have to be in a category in Section 9.3.6.
        - The HRPP Director will report the inclusion of the prisoner-subject to the DoD sponsor within 14 days of the convened meeting.
    - Research may not involve detainees (persons captured, detained, held, or otherwise under the control of DoD personnel, but not persons being held primarily for law enforcement purposes). This prohibition does not apply to research involving an investigational drug or device when the same product would be offered to members of the US military in the same location for the same medical condition.
    - Research may not involve Prisoners of War. The IRB is aware of the definition of “prisoner of war” for the DoD component supporting the research.
- For Section 9.4 (Pregnant Persons, Fetuses, and Neonates):
    - The phrase “biomedical knowledge” is replaced by “generalizable knowledge,” and applies to research with pregnant persons that is more than minimal risk and includes interventions or invasive procedures to the woman or the fetus and to research with fetuses and neonates as human subjects.
    - Fetal research must comply with the US Code Title 42, Chapter 6A, Subchapter III, Part H, 289g.
- For Section 9.5 (Decisionally-Impaired Persons), to be approvable, the research must intend to benefit the individual subject, for research involving a human being as an experimental subject, meaning an activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction.

12.10.11 DoD-Specific Requirements for Waiver of Consent

(Revised 6/29/17)
For classified research or research involving a human being as an experimental subject, meaning an activity, for research purposes, where there is an intervention or interaction with a living individual for the primary purpose of obtaining data regarding the effect of the intervention or interaction, the IRB will not waive or alter the requirement for informed consent under Section 8.4.3 or 8.4.4 unless the Secretary of Defense (or the Secretary of the Navy for research subject to Department of the Navy requirements) has granted a waiver of consent for the research project. If the research involves a human being that does not meet the definition of an experimental subject, the IRB is allowed to waive or alter the requirement for consent under Section 8.4.3 or 8.4.4.

The Assistant Secretary of Defense for Research and Engineering may waive the requirements for consent when all of the following are met:
- The research is necessary to advance the development of a medical product for the Military Services; and
- The research might directly benefit the individual experimental subject; and
- The research is conducted in compliance with all other applicable laws and regulations.

12.10.12 DoD-Specific Requirements for Subject Payment

(Revised 2/24/17)
Subjects who are on-duty federal personnel and subjects who are off-duty federal personnel in federally-funded research may be compensated up to $50 for each blood draw for scientific or research purposes connected with the care of any person entitled to treatment at Government expense, but not be otherwise compensated for general research participation.

These limitations on payments do not apply to subjects who are off-duty federal personnel or non-federal personnel, except that payment to off-duty federal personnel for general research participation must not be directly from a Federal source (payment from a Federal contractor or other non-Federal source is permissible).

12.10.13 DoD-Specific Requirements for Survey Research

(Revised 9/28/16)
The Principal Investigator for any DoD-supported research involving surveys is responsible for arranging for the review of the survey by the appropriate DoD component. This review is in addition to review by the IRB.

12.10.14 DoD-Specific Requirements for DoD Oversight

(Revised 9/28/16)
The HRPP will support the oversight by the sponsoring DoD component, including communicating to the sponsoring DoD component about:

- information needed to assure that the approval of the initial submission is in compliance with all applicable requirements; and
- IRB-approved substantive changes, including a notification that the Principal Investigator is informed that the changes cannot be implemented prior to acceptance by the sponsoring DoD component; and
- the results of the continuing review
- other information reported as required by Section 12.10.7

The HRPP will also cooperate with any requests by the sponsoring DoD component for a site visit.

12.10.15 DoD-Specific Requirements for Conflict of Interest

(Revised 9/28/16)
For research subject to Department of the Navy requirements, investigators, key research personnel, IRB members, and other personnel must disclose all conflicts of interest, including any financial interests for themselves, spouses, and dependent children. No person shall be involved in any review or approval of a protocol when there may be a conflict of interest.

12.10.16 DoD-Specific Requirements for Multi-Site Research

(Revised 6/29/17)
For DoD-supported multi-site research, there will be a formal agreement between organizations that specifies the roles and responsibilities of each party.

13 Definitions

(Revised 1/29/22)
Adverse Event (AE) is any untoward or unfavorable 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.

Children are defined as persons who have not attained the legal age for consent to treatments or procedures involved in the research.

Clinical investigation is defined as any experiment that involves a test article and one or more human subjects and that is either subject to requirements for prior submission to the FDA, or the results of which are intended to be submitted later to, or held for inspection by, the FDA as part of an application for a research or marketing permit.

Clinical trial is defined as any research project that prospectively assigns people or a group of people to an intervention, with or without concurrent comparison or control groups, to study the cause-and-effect relationship between a health-related intervention and a health outcome. Health-related interventions are those used to modify a biomedical or health-related outcome; examples include drugs, surgical procedures, devices, behavioral treatments, educational programs, dietary interventions, quality improvement interventions, and process-of-care changes. Health outcomes are any biomedical or health-related measures obtained in patients or participants, including pharmacokinetic measures and adverse events.

Employee or agent of an institution is an individual who acts on behalf of, exercises authority or responsibility for, or performs activities designated by that institution**.**

Exempt research is research that meets the definition of human subjects research but is not required to meet all of the criteria for approval because all of the research activities qualify for one or more specified exempt categories.

Expedited review is review by one or more experienced reviewers rather than at a convened IRB meeting.

Health Information Identifiers are any of the following of an individual or of relatives, employers, or household members of the individual:

1. Names; or
2. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census:
    - The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and
    - The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000; or
3. All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older; or
4. Telephone numbers; or
5. Fax numbers; or
6. Email addresses; or
7. Social security numbers; or
8. Medical record numbers; or
9. Health plan beneficiary numbers; or
10. Account numbers; or
11. Certificate/license numbers; or
12. Vehicle identifiers and serial numbers, including license plate numbers; or
13. Device identifiers and serial numbers; or
14. Web Universal Resource Locators (URLs); or
15. Internet Protocol (IP) addresses; or
16. Biometric identifiers, including finger and voice prints; or
17. Full-face photographs and any comparable images; or

18. Any other unique identifying number, characteristic, or code, including any code that includes or is derived from any of the identifiers on this list.

Human subject is defined as a living individual:

1. About whom a researcher obtains information or biospecimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or biospecimens; or
2. About whom a researcher obtains, uses, studies, analyzes, or generates identifiable private information about the individual or identifiable biospecimens; or
3. Who is or becomes a subject (either a healthy human or a patient) in research, either as a recipient of the test article or as a control, or upon whose specimens, either identified or not identified, an investigational device is used.

Intervention includes both physical procedures by which information or biospecimens are gathered (for example, venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes. Interaction includes communication or interpersonal contact between investigator and subject. 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 (for example, a medical record). Identifiable private information is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information). An identifiable biospecimen is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

Limited Data Set is Protected Health Information (PHI) that does NOT include any of the following 16 categories of direct identifiers, but that may include city, state, ZIP code, or elements of dates, concerning an individual or an individual’s relatives, employers, or household members:

1. Names; or
2. Postal address information, other than town or city, state, and ZIP Code; or
3. Telephone numbers; or
4. Fax numbers; or
5. Electronic mail addresses; or
6. Social security numbers; or
7. Medical record numbers; or
8. Health plan beneficiary numbers; or
9. Account numbers; or
10. Certificate/license numbers; or
11. Vehicle identifiers and serial numbers, including license plate numbers; or
12. Device identifiers and serial numbers; or
13. Web universal resource locators (URLs); or
14. Internet protocol (IP) address numbers; or
15. Biometric identifiers, including fingerprints and voiceprints; or
16. Full-face photographic images and any comparable images.

Minimal risk means that 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 examinations or tests.

Personal Information means a Massachusetts resident's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" does not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

Prisoner means any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures which provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing.

Protected Health Information (PHI) is individually identifiable health information that is held or transmitted by a covered entity (a health plan, health care clearinghouse, or health care provider) or its business associate, in any form or media, whether electronic, paper or oral. Health information is information, including demographic data, that relates to the individual's past, present or future physical or mental health or condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual. Health care encompasses care, services, or supplies related to the health of an individual, including (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. Individually identifiable means that the information identifies the individual or there is a reasonable basis to believe it can be used to identify the individual.

Research is defined as a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. For purposes of this definition, a systematic investigation is the use of a predetermined method to gain information by collecting and analyzing data. Generalizable knowledge is conclusions that can be applied to circumstances outside of the specific instances of the investigation.

Repository is a system or facility that collects, stores, and distributes identifiable data or identifiable biological samples obtained from living persons for research use. This research use is facilitated through the repository's established plans for sharing, either with the repository investigators who collected the data or samples, or with other investigators. Repository activities involve three components: (i) the collection of the data or biological samples; (ii) the repository storage, maintenance, and management of the data or samples; and (iii) the plans and activities for use or sharing for research. A repository does not involve a study rationale, study objective(s), or the hypotheses to be tested, as the activities are limited to the collection, storage, and distribution, with no associated research analyses. Identifiable information is information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information. An identifiable biological sample is a biospecimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the biospecimen.

Serious Adverse Event (SAE) is any adverse event that

(1) results in death;
(2) is life-threatening (places the subject at immediate risk of death from the event as it occurred);
(3) results in inpatient 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) 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 dyscrasias or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse).

Significant Financial Interest (as defined by Boston Medical Center and Boston University policies on research conflicts of interest) means:

1. A financial interest consisting of one or more of the following interests of an Investigator (and those of the Investigator's spouse or dependent children), that reasonably appears to be related to the Investigator's Institutional Responsibilities:
   a. With regard to a publicly traded entity, a *significant financial interest* exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure and the

value of any equity interest in the entity as of the date of disclosure, when aggregated, exceeds $5,000. Remuneration includes salary and any payment for services not otherwise identified as salary (e.g., consulting fees, honoraria, paid authorship fees). Equity interest includes any stock, stock option or other ownership interest, as determined through reference to public prices or other reasonable measures of fair market value;

b. With regard to a non-publicly traded entity, a *significant financial interest* exists if the value of any remuneration received from the entity in the twelve months preceding the disclosure, when aggregated, exceeds $5,000 or when the Investigator (or the Investigator's spouse or dependent children) holds any equity interest (e.g., stock, stock options, or other ownership interests);
c. Intellectual property rights and interests (e.g. patents, copyrights) upon receipt of income related to such rights and interests; and
d. For PHS-Funded Investigators only: a *significant financial interest* also includes Travel, which means reimbursed or sponsored travel (i.e., that which is paid on behalf of the Investigator and not reimbursed to the Investigator so that the exact monetary value may not be readily available), related to an Investigator's Institutional Responsibilities that exceeds $5000 in value (in aggregate from a single entity). The disclosure of Travel will include at a minimum, the purpose of the trip, the identity of the sponsor/organizer, the destination and the duration. The disclosure requirement for Travel does not apply to any travel that is reimbursed or sponsored by one of the following within the United States: a Federal, state, or local government agency, an Institution of higher education as defined at 20 U.S.C. 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education.

2. Exceptions: "Significant Financial Interest" does not include the following financial interests:
   a. Salary, royalties, or other remuneration paid by Boston Medical Center or Boston University to the Investigator, if the Investigator is currently employed or is otherwise appointed by the Institution making the payment;
   b. Intellectual property rights assigned to either Boston Medical Center or Boston University and agreements to share in royalties related to such rights;
   c. Income from investment vehicles, such as mutual funds and retirement accounts, as long as the Investigator does not directly control the investment decisions made in these vehicles;
   d. Income from seminars, lectures, teaching engagements, sponsored by one of the following within the United States: a Federal, state, or local government agency, an institution of higher education as defined at 20 U.S.C. 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education; and
   e. Income from service on advisory committees or review panels for one of the following within the United States: a Federal, state, or local government agency, an institution of higher education as defined at 20 U.S.C. 1001(a), an academic teaching hospital, a medical center, or a research institute that is affiliated with an Institution of higher education.

Significant Financial Interest related to the research (as defined by Boston Medical Center and Boston University policies on research conflicts of interest) is a significant financial interest for which (1) the investigator's interest could be reasonably affected by the research or (2) the entity in which the investigator has an interest could reasonably have its financial interests affected by the research.

Unanticipated Problem is defined as an event, experience or outcome that meets **all three** of the following criteria:

- is 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; AND
- is related or possibly related to participation in the research (in this guidance document, *possibly related* means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the procedures involved in the research); AND
- suggests that the research places subjects or others at a greater risk of harm (including physical, psychological, economic, or social harm) than was previously known or recognized.

14 Abbreviations and Acronyms

(Revised 8/11/19)
AAHRPP – Association for the Accreditation of Human Research Protection Programs
BU CTSI – Boston University Clinical and Translational Science Institute
CDC – Centers for Disease Control
CoC – Certificate of Confidentiality
CRRO – Clinical Research Resources Office
DoD – Department of Defense
GCP – Good Clinical Practices
GINA – the Genetic Information Nondiscrimination Act
FWA – Federalwide Assurance
HDE – Humanitarian Device Exemption
HIPAA – Health Insurance Portability and Accountability Act of 1996
HRPP – Human Research Protection Program
HUD – Humanitarian Use Device
ICH-GCP – International Conference on Harmonisation-Good Clinical Practices
IND – Investigational New Drug
IDE – Investigational Device Exemption
IO – Institutional Official
IRB – Institutional Review Board
IT – Information Technology
LIP – Licensed Independent Practitioner
NIH – U.S. National Institutes of Health
OHRP – U.S. Office of Human Research Protections
PHI – Protected Health Information
QA – Quality Assurance
QI/QA – Quality Improvement/Quality Assurance
VAMC – Veterans Administration Medical Center

15 Revision History

Approved 1/14/2003, 2/2/2010
Revisions approved 10/3/2014
- Section VI. Principal Investigators, Co-investigators and Other Research Personnel (Adverse Event Reporting)

Revisions approved 3/13/2015
- Section VIII. Informed Consent (Use of External Sponsor Drafted Consent Forms)

Revisions approved 4/10/2015
- Section VI. Principal Investigators, Co-investigators and Other Research Personnel (Adverse Event Reporting)

Revisions approved 2/12/2016
- Section VI. Principal Investigators, Co-investigators and Other Research Personnel (Adverse Event Reporting)

Revisions approved 3/28/2016
- All sections. Formatting and typo corrections; updates: FWA-related changes, institutional language changes, legal reference corrections, electronic system details, panel details, recertification procedure, response deadlines, consent form stamping, PI eligibility
- Section II. International Research – content modified
- Section VI. Principal Investigators, Co-investigators and Other Research Personnel (Study Closure – section name changed from Final Report, content modified)
- Section VI. Principal Investigators, Co-investigators and Other Research Personnel (New section: Registration Requirements for Clinical Trials)

Revisions approved 4/25/2016
- All sections. Section and subsection headings have been renumbered, edited, and added
- Sections dated 3/28/16 – no additional changes
- Sections dated 4/25/16 – incorporation of existing policies, and in addition:
  - Section 1.2 – specifying the plan for updating this document
  - Section 6.6.2.5.2 – specifying that when changes are made to eliminate an immediate hazard, this meets the definition of an Unanticipated Problem

  - Section 6.6.5.2 – specifying reporting for changes made to eliminate an immediate hazard
  - Section 10.2.2.1 – specifying the process for designating Expediters
  - Section 10.2.2.4.2 – specifying criteria for minor modifications
  - Section 10.4.2 – specifying the process for verifying no unapproved changes have occurred
  - Section 11.4 – specifying responsibilities for subject safety when approval is suspended or terminated

Revisions approved 5/27/16

- Sections dated 5/27/16 – incorporation of existing policies, and in addition:
  - Section 1.3.2.4 – specifying a timeline for the HRPP quality improvement process
  - Sections 2.1.2, 8.1.3.4, 9.2.4.5, 9.3.1, 9.3.4, 9.4.1, 9.4.3, 10.2.2.4.1.1, 10.2.2.4.1.2, 10.2.2.4.1.3, 10.2.4.1, 10.2.4.2.2, 10.2.4.3, 10.4.1.1, and 10.4.1.3 – adding equivalent protection standards for minimal risk research not required to follow federal regulations
  - Section 6.6.3.2 – changing the reporting requirement to 7 days for Unanticipated Problems not associated with a fatal or life-threatening incident
  - Sections 7.2.1 and 7.2.2.2 – specifying when a separate protocol is required in the submission
  - Section 8.4.5.1 – changing the required attestation for translations from a second translator to the PI
  - Section 9.2.4.5 – specifying how the availability of the second parent for permission for child research is interpreted
  - Section 9.5.1 – allowing the IRB to approve research with decisionally-impaired subjects that is a minor increase over minimal risk and is likely to generate important knowledge about the subjects' condition
  - Sections 10.2.1.2 and 10.2.2.4.2.1 – specifying that the IRB will determine whether new or modified consent forms must be used for already-consented subjects
  - Section 10.2.2.4.2.2 – specifying the criteria used by the Chair or Vice-Chair for approving protocol exceptions
- Sections 6.3.3, 6.6.4.3, 6.6.5.4, 6.6.5.5 – deleted (all information appeared elsewhere in the document)

Revisions approved 6/30/16

- Sections dated 6/30/16 – incorporation of existing policies, and in addition:
  - Sections 1.3.2.4 and 11.3.3 – adding a scheduled analysis of audit and QA review results
  - Sections 3.1.1, 3.2, 10.2.1.6, and 11.4.3.5 – adding an Executive Board
  - Section 3.9 – altered Conflict of Interest processes for IRB meetings
  - Section 5.3 – altered confidentiality processes for IRB meetings
  - Sections 6.2.3.1, 6.2.3.2, and 6.4.3 – adding requirements for training in Good Clinical Practices and training for sponsor-investigators
  - Section 6.6.1 – adding a comprehensive list of PI responsibilities
  - Sections 6.6.2.5.4, 6.6.5.2, and 6.6.5.3 – specifying that a lapse in IRB approval is a major deviation if human subjects research takes place during the lapse and minor otherwise and that overenrolling is a major deviation for studies that are greater than minimal risk and minor otherwise
  - Section 11.3.5 – specifying annual QA reviews for sponsor-investigator studies
  - Section 11.3.11 – specifying that PIs are expected to notify the CRRO about an upcoming FDA audit
  - Section 11.4.2 – criteria for serious or continuing noncompliance
  - Section 11.4.3.1 – specifying a hierarchy for decisions about noncompliance
  - Section 11.5 – adjusting the timeframe for external reporting of suspension or termination of IRB approval
- Section 10.3.1 – deleted (unnecessary information)
- Throughout document – section cross-references converted to hyperlinks – TIP: use Alt+Left Arrow Key to return from a hyperlink

Revisions approved 7/25/16

- Sections dated 7/25/16 – incorporation of existing policies, and in addition:
  - Sections 1.3.2.4, 3.3.2, 3.3.5, 3.4.1.2, 3.4.1.3, 3.4.1.4, 3.4.2.2, 3.4.2.4, 3.4.3.3, 3.4.3.4, 3.4.4.2, and 3.5.2: Evaluation of IRB members
  - Sections 2.5.4 and 6.6.3.2: Reporting requirements for multi-site research
  - Section 6.1.3.4: Specifying that the Faculty Sponsor has the same ultimate responsibilities as the Principal Investigator
  - Section 7.2.2.6.2: Requiring confirmation by the PI of compliance with prohibitions on bonus payments, kickbacks, and finders fees
  - Sections 7.2.2.7.1 and 10.1.1.2.5: Requiring a description of subject privacy protections
  - Section 7.2.2.20: Changing the effective date of the requirement for a separate protocol
  - Section 7.4.1.1: Specifying the process for assuring that new Principal Investigators and Faculty Sponsors acknowledge their responsibilities
  - Sections 7.4.3, 7.4.4, 10.2.4.1, and 10.2.4.4: Expiration of exempt determinations after three years.
  - Section 10.2.3: Evaluation of requests to cede review to another IRB
- Sections 3.1.1, 3.1.2.1, 3.1.2.2, and 3.1.2.3 – deleted (information that is still correct incorporated into other sections)
- Sections 7.1.1, 7.1.2, 7.1.3, and 7.1.4 – deleted (information that is still correct incorporated into Section 7.1)

- Section 7.2.2.3.2 – deleted (incorporated into 7.2.2.6.3)
- Section 10.2.3 (Review by IRB Subcommittee) – deleted (unnecessary information), numbered section replaced with Evaluation of Requests to Cede Review

Revisions approved 8/30/16

- Sections dated 8/30/16 – incorporation of existing policies, and in addition:
  - Section 4.4.3 – IRB minutes are maintained electronically.
  - Section 5.6 – IRB minutes may be approved by the board by a general consent process.
  - Section 7.2.2.7.2.2 – requiring information on release of identifiable information to include any planned mandated reporting (e.g., child abuse, communicable diseases, or suicide risk).
  - Sections 8.1.1 and 8.4.1 – requiring the signature on the consent form of the person conducting the consent discussion, effective for initial submissions on or after November 1, 2016.
  - Section 8.1.3.5 – requiring basic information on the first page of sponsor-provided consent forms, effective for initial submissions on or after November 1, 2016.
  - Sections 8.2.1 and 8.2.2 – requiring that studies conducted under ICH-GCP include elements required under ICH-GCP.
  - Section 8.2.2 – requiring two additional elements of informed consent if applicable to the study, effective for initial submissions on or after November 1, 2016.
  - Section 8.2.3 – requiring the consent form to disclose any planned mandated reporting.
  - Section 8.2.4 – requiring the consent form to disclose any planned inclusion of de-identified data in an NIH genetic repository.
  - Sections 8.4.5.2 and 8.4.5.3 – requiring the use of an additional witness signature section for use with short-form consent forms.
  - Section 8.4.6 – requiring the IRB to determine for each study whether limited- and non-readers are permitted to be included and requiring consent forms to include a witness signature when limited- and non-readers are permitted.
  - Section 9.2.4.3 – requiring the person obtaining consent to document child assent.
  - Section 9.4.9 – requiring certain information to be given to pregnant partners of male research subjects when their and their child's health information is requested.
  - Section 9.7.2 – requiring the IRB to determine whether research requiring a Certificate of Confidentiality (CoC) may start before the CoC is obtained.
  - Sections 9.8.1, 9.8.2, and 9.8.3 – specifying additional required protections when the research targets homeless individuals, terminally ill individuals, or individuals with psychiatric disorders.
  - Section 9.9 – requiring a suicide safety protocol if the research is likely to obtain information indicating that an individual is at risk of self-harm.
- Section 5.7 – deleted as redundant with Section 10.5
- Section 10.2.7.2 – renumbered from 10.2.2.4.4 to reflect administrative review of final reports
- Section 10.6 – deleted as redundant with Section 10.3.2.4

Revisions approved 9/28/16

- Sections dated 9/28/16 – incorporation of existing policies, and in addition:
  - Section 2.3.1 – specifying responsibilities for assuring adequate resources for the HRPP
  - Section 3.3.1 – specifying how competing business interests are separated from ethics review functions
  - Sections 7.2.2.6.4 and 8.1.3.4 – specifying when consent for screening can use an abbreviated consent process
  - Section 11.5 – specifying a process for notifying subjects when approval for a study is suspended or terminated

Revisions approved 10/31/16

- Sections dated 10/31/16 – incorporation of existing policies, and in addition:
  - Section 2.3.3 – adding a contingency plan in case the IRB is unable to continue oversight
  - Sections 7.2.2.7.2.3.1, 7.2.2.7.2.3.2, 8.2.4, and 8.2.6 – specifying considerations for plans for returning pertinent and incidental findings.
  - Sections 7.2.2.22 and 7.2.2.23 – adding a requirement for risk information in Individual Patient IND and Humanitarian Use Device submissions, respectively
  - Sections 10.2.4.2.2 and 10.2.4.3 – adding an equivalent protections exempt category for Quality Improvement research

Revisions approved 11/29/16

- Sections dated 11/29/16 – incorporation of existing policies, and in addition:
  - Sections 2.7.2 and 2.7.3 – describing community outreach and engagement activities
  - Section 3.2 – adding the expectation that at least 75% of panel meetings will have one or more unaffiliated members in attendance
  - Section 3.3.1 – adding an annual assessment of member meeting attendance
  - Sections 4.4.2, 6.6.7.1, and 8.3.3 – establishing a uniform 7-year record retention period

  - Section 6.1.3.4 – allowing student research to be submitted as an amendment to an already-approved project
  - Section 6.7 – adding expectations for sponsors
  - Sections 7.2.2.6.5 and 8.1.3.4 – clarifying and simplifying the requirements for when screening requires a full consent form
  - Section 9.3.4 – allowing expedited review of prisoner research that involves no interactions with prisoners
  - Section 10.2.5.2.2 – specifying when Quality Improvement/Quality Assurance projects are not considered human subjects research

Revisions approved 12/19/16

- Sections dated 12/19/16 – incorporation of existing policies, and in addition:
  - Sections 1.2, 3.4.3.3, 3.4.4.3, and 11.1 – specifying a process for making exceptions to these policies and procedures
  - Section 6.2.3.2 – specifying that human subjects protection training must be renewed by taking the CITI refresher course for human subjects protection
  - Sections 7.2.2.12.1 and 8.4.6 – revisions to the policies for limited- and non-readers
  - Sections 8.1.3.5, 10.2.4.1, 10.2.4.2.2, and 10.2.4.3 – allowing exempt determinations to be made by an IRB of record with which the Boston Medical Center and Boston University Medical Campus IRB has a reliance agreement
  - Section 8.5.2.2 – specifying that protocol-specific justifications will be provided for waiver of HIPAA authorization
  - Section 10.2.5.2.3 – specifying when case reports require IRB review
  - Section 11.4.2 – clarifying when noncompliance is serious or continuing

Revisions approved 1/30/17

- Sections dated 1/30/17 – incorporation of existing policies, and in addition:
  - Sections 6.2.1.2 and 7.2.2.2 – requiring a CRRO consultation or IRB Director waiver for investigator-initiated clinical trials
  - Section 6.2.3.1 – requiring GCP training for already-approved NIH-supported clinical trials
  - Section 7.2.2.16.4 – requiring the submission of information on the process for release of samples or data that are retained for extra use by other investigators
  - Sections 7.2.2.18 and 9.4.8 – removing the requirement for pregnancy testing prior to research-only non-contrast MRIs
  - Section 8.2.5 – specifying required information in consent forms for studies involving repositories or retention of samples or data
  - Section 9.7.2 – specifying considerations for Certificates of Confidentiality for genetic data in an NIH repository

Revisions approved 2/24/17

- Sections dated 2/24/17 – incorporation of existing policies, extensive formatting and wording changes, and adding Section 14, Abbreviations and Acronyms. In addition:
  - Section 3.8 – adding the use of informal consultants by IRB members
  - Sections 3.9, 6.1.3.3, 6.1.3.4, 6.2.2, 6.2.3.1, 6.6.6, 7.2.2.2, 7.4.1.1, 10.2.7.1 – changing “Faculty Sponsor” to “Supervising Principal Investigator”; removing mention of fellows with faculty appointments (no longer occurs); specifying that Supervising Principal Investigators will receive the same communications as the student/trainee PI

Revisions approved 3/21/17

- Sections dated 3/21/17 – incorporation of existing policies, and in addition:
  - Section 8.1.3.6 – specifying that subjects who withdraw must consent for collection of follow-up data

Revisions approved 5/30/17

- Sections dated 5/30/17 – minor corrections and clarifications, and in addition:
  - Sections 7.2.2.12.3 and 8.4.3 – adding the condition for approval of a waiver of consent that research with identifiable data or biospecimens could not be practicably carried out with deidentified data or biospecimens
  - Section 8.2.1 – adding a required element of consent that deidentified data or biospecimens might be used for future research studies
  - Section 10.2.4.2.1 – clarifying some exempt categories for all research
  - Section 10.2.4.2.2 – modifying some exempt categories for equivalent protections
  - Section 10.2.4.3 – modifying abbreviated consent requirements for exempt research
  - Sections 10.2.5.1 and 13 – clarifying the definition of a human subject to include identifiable biospecimens
  - Section 10.2.5.2.1 – specifying certain activities not considered to constitute research

Revisions approved 6/29/17

- Sections dated 6/29/17 – minor corrections and clarifications, and in addition:
  - Section 7.2.2.9 – adding a requirement that the description of how risks will be minimized must include, if appropriate, what resources are available to subjects

  - Sections 7.2.2.14.5 and 7.2.2.20 – adding a requirement that investigators must describe how they will have access to a population that will allow recruitment of enough subjects
  - Section 9.3.1 – clarifying the requirements for research initially approved without the inclusion of prisoners when an enrolled subject becomes incarcerated

Revisions approved 10/27/17

- Sections dated 10/27/17 – minor corrections and clarifications, and in addition:
  - Sections 7.2.2.14.1 and 7.2.2.20 – adding the requirement for a description of the plan for inservice training if any nursing staff are expected to interact with subjects
  - Sections 7.2.2.8.1, 7.2.2.8.2, and 10.1.1.2.9 – adding requirements for disclosure and management of any investigator's intellectual property interest in a drug, biological agent, or device used in the study

Revisions approved 11/06/17

- Sections dated 11/06/17 – minor corrections and clarifications

Revisions approved 12/14/17

- Sections dated 12/14/17 – minor corrections and clarifications, and in addition:
  - Sections 7.4.1.1, 7.4.1.2, and 7.4.1.3 – establishing administrative review for changes in contact information in consent forms and other subject materials
  - Section 8.4.3 – allowing waiver or alteration of consent for minimal risk clinical investigations
  - Section 12.4.5 – updating requirements for off-label use of Humanitarian Use Devices (HUDs)

Revisions approved 1/17/18

- Sections dated 1/17/18 – minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 6.6.2.2, 7.4.3.2, 10.1.3, 10.2.2.4.3.2, 10.4.1.1, 10.4.1.4.1, 10.4.1.4.2, and 10.4.1.4.3 – specifying that research may be approved or be given an expedited determination without an expiration date and establishing the requirement for a three-year check-in for such research after 7/19/18
  - Sections 7.2.2.7.2.5 and 9.7.2 – new requirements for Certificates of Confidentiality
  - Sections 8.2.1.1, 8.4.3, and 8.4.5.2 – new requirements for consent forms
  - Sections 10.2.4.1, 10.2.4.2.1.2, 10.2.4.2.2.2, and 10.2.4.4 – new and revised exempt categories after 7/19/18

Revisions approved 2/19/18

- Sections dated 2/19/18 – minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 6.5.1, 7.2.2.5, and 13: Asking about disclosures of Significant Financial Interests only if related to the research.

Revisions approved 5/18/18

- Sections dated 5/18/18 – minor corrections and clarifications, and in addition:
  - Sections 11.2.4.2.2.1, 11.2.4.2.2.2, and 10.2.4.3: Adding an equivalent protections exempt category for minimal risk research without external funding with adult subjects able to provide abbreviated consent.

Revisions approved 6/20/18

- Sections dated 6/20/18 – changing the effective date of the Final Common Rule to January 21, 2019

Revisions approved 8/16/18

- Sections dated 8/16/18 – minor corrections and clarifications, and in addition:
  - Section 2.3.1: Identifying the Institutional Official for Boston University Medical Campus
  - Sections 2.4, 8.5.1, and 10.2.6: Requiring an IRB submission for certain recruitment activities for studies where Boston Medical Center and Boston University are not engaged.
  - Section 8.5.2.2: Requiring a waiver of HIPAA authorization from the Boston Medical Center and Boston University Medical Campus IRB for release of PHI for studies where Boston Medical Center and Boston University are not engaged.
  - Section 11.3.9.1: Specifying that the QA Manager will review RENIs for accuracy

Revisions approved 9/25/18

- Sections dated 9/25/18 – minor corrections and clarifications, and in addition:
  - Sections 7.2.2.18 and 10.2.3: Specifying additional criteria for BMC or BU Medical Campus relying on a commercial IRB
  - Section 8.4.1: Specifying a process for documenting consent when a subject is physically unable to provide a written signature
  - Sections 10.2.1.3 and 10.2.2.4.2.1: Specifying criteria for when subjects should be re-consented
  - Sections 11.3.8, 11.3.9.3, and 11.4.3.3: Specifying a reporting process for incidents involving privacy

Revisions approved 10/22/18

- Sections dated 10/22/18 – minor corrections and clarifications, and in addition:
  - Sections 2.5.2 and 2.5.3 : Specifying additional details concerning reliance agreements and oversight responsibilities for multi-site research, including the responsibility of the lead PI to communicate with external sites Section 2.5.4 Specifying local PI's responsibility when relying on an external IRB
  - Sections 7.4.1.2 and 10.2.3.2: Establishing the process for adding external sites to a multi-site study
  - Section 10.2.3: Specifying the process for evaluating requests to cede review and to serve as the IRB of record

Revisions approved 12/24/18

- Sections dated 12/24/18 – minor corrections and clarifications, and in addition:
  - Section 6.6.9: Adding the requirement for posting consent forms for Federally-supported clinical trials
  - Section 8.4.5.1: Clarifying the requirement for a Translator Qualification form for translation of revised consent forms and other study materials
  - Section 12.1.1: Updating the review process for individual patient INDs

Revisions approved 1/26/19

- Sections dated 1/26/19:
  - Sections 3.2 and 3.4.6.1: Specifying nursing representation requirements

Revisions approved 3/13/19

- Sections dated 3/13/19 – minor corrections and clarifications, and in addition:
  - Sections 11.3.2, 11.3.8, and 11.3.9.1: Updating QA Review procedures

Revisions approved 6/23/19

- Sections dated 6/23/19 – minor corrections and clarifications, and in addition:
  - Sections 6.6.3.2 and 11.3.8: Setting a uniform 7-day reporting deadline for Unanticipated Problems
  - Sections 7.2.2.7.2.1, 7.2.2.7.2.2, 7.2.2.10, 7.2.2.19, and 10.2.4.2.2.2: Adding new requirements for submission and evaluation of confidentiality protections
  - Sections 7.2.2.12.1, 7.2.2.18, 8.1.3.7, and 10.2.3.1: Adding new requirements for individuals involved in the consent process

Revisions approved 8/11/19

- Sections dated 8/11/19 – minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 2.1.2 and 2.5.1: adding the requirement for single IRB review of federally-supported multi-site research with a compliance date of January 20, 2020.
  - Sections 2.5.3.1, 2.5.3.2, 8.5.2.2, and 10.2.3.1.1: specifying that waivers of HIPAA authorization for ceded studies will be the responsibility of the Boston Medical Center and Boston University Medical Campus IRB for studies with cede requests submitted on or after September 1, 2019.
  - Sections 2.5.4, 6.6.2.2, 7.4.3.2, 10.2.3.1.1, 10.2.3.1.2, and 10.4.1.5: Requiring a Status Check-In Report for studies with cede requests submitted on or after September 1, 2019.
  - Sections 3.4.3.3 and 10.8: specifying reporting requirements to AAHRPP
  - Section 7.2.2.16.6: requiring the CV of the Principal Investigator for external sites where the Boston Medical Center and Boston University Medical Campus IRB is the IRB of record
  - Section 7.2.2.18: requiring additional specific information about recruitment and subjects for ceded studies
  - Section 7.4.1.2: requiring amendment applications to describe plans for re-consenting subjects

Revisions approved 9/22/19

- Sections dated 9/22/19 – minor corrections, consistency changes, and clarifications, and in addition:
  - Section 7.2.2.2: adding special routing of initial submissions for studies involving Boston Healthcare for the Homeless, a nurse as the Principal Investigator, or students from the Goldman School of Dental Medicine.
  - Section 9.3.5: clarifying when review by a prisoner representative is required.
  - Section 10.4.1.1: specifying that an expiration date may be established for studies where the Boston Medical Center and Boston University Medical Campus IRB is serving as the IRB of record for one or more external sites.
  - Section 13: clarifying that a Significant Financial Interest includes income and travel from government or academic entities outside the United States.

Revisions approved 11/18/19

- Sections dated 11/18/19 – minor corrections, consistency changes, and clarifications, and in addition:
  - Section 7.2.2.2: adding special routing of initial submissions for studies involving procuring or processing samples through BMC Pathology or the involvement of BMC Laboratory Medicine services.
  - Sections 7.2.2.6.5 and 8.1.3.4: clarifying requirements for consent for screening.

Revisions approved 2/17/20

- Sections dated 2/17/20 – minor corrections, consistency changes, and clarifications, and in addition:
  - Section 6.6.9: adding a requirement for clinical trial results, if required to be posted on ClinicalTrials.gov, be submitted no later than 10 months after the primary completion date
  - Sections 7.2.2.7.2.2 and 7.2.2.18: adding a requirement for specifying the date upon which the study team initiated a security review for studies where data will be shared with a third party application
  - Section 7.2.2.8.2: adding a requirement for device study submissions to describe the process for control of investigational devices
  - Section 7.2.2.20: allowing the IRB Director or an IRB Chair to determine that a particular study must have a separate protocol.

- Sections 7.4.1.2 and 7.1.4.4: Establishing requirements for submission of promotional recruitment materials
- Section 12.9: updating Department of Energy requirements

Revisions approved 8/24/20

- Sections 5.7, 6.5.2, and 10.1.1.2.9: clarifying the review of conflict of interest management plans

Revisions approved 9/15/20

- Sections dated 9/15/20 – minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 3.3.2, 3.3.5, 3.4.1.2, 3.4.1.4, 3.4.2.2, 3.4.2.4, and 3.4.4.4: specifying the frequency of board member evaluations
  - Sections 5.7, 8.4.6, and 10.5.3: specifying that limited- and non-readers should be included as subjects unless the IRB determines their exclusion is justified
  - Sections 7.2.2.17, 10.2.5.1, and 10.2.5.4: new requirements for research using publicly-available information
  - Section 12.10.8: incorporating the change in the DoD requirement for a research monitor

Revisions approved 12/20/20

- Sections dated 12/20/20 – minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 7.2.2.7.2.1, 7.2.2.7.2.2, and 7.2.2.18: specifying data security review is not required when using an approved option
  - Sections 7.2.2.8.1 and 12.1.2: clarifying investigator confirmation for IND exemptions

Revisions approved 3/29/21

- Sections 7.2.2: adding the requirement for completion and sign-off of the “Reducing Implicit and Explicit Bias in Research” form, and; adding a question regarding whether a study involves in-person subject interaction in Boston Medical Center clinical space, and; adding requirement for sign-off by the Boston Medical Center Chief Medical Officer if the study targets Boston Medical Center employees.
- Section 7.3.2: adding a requirement for Department Chair/Section Chiefs to review and sign-off on the “Reducing Implicit and Explicit Bias in Research” form
- Section 12.2.6: clarifying that the IRB’s determinations regarding IDE exemptions are made in the IRB staff review for studies reviewed via the expedited procedure

Revisions approved 4/18/21

- Sections dated 4/18/21 - minor corrections, consistency changes, and clarifications, and in addition:
  - Section 3.3.5: modifying eligibility criteria for inclusion in the biennial IRB member evaluation process
  - Sections 10.2.5.2.2: clarifying criteria that define Quality Improvement and Quality Assurance activities

Revisions approved 6/01/21

- Sections dated 6/01/21 - minor corrections, consistency changes, and clarifications, and in addition:
  - Section 7.2.2.1 and 7.2.2.19: adding section 7.2.2.16.4 as a potential submission requirement for the exempt review path
  - Section 7.2.2.16.1: adding a new option for the management of human subjects training for international researchers who are overseen by the local IRB
  - Sections 7.2.2.16.4: adding a delineation between repositories and studies with the retention of biological samples or data for extra use by the study investigator(s) or by other investigators. Also, adding questions to capture the reasons for a new repository and a description of the process for executing DUAs/MTAs prior to sharing data/samples
  - Section 8.2.5 and 10.2.4.3: clarifying that the abbreviated consent process for exempt research must also include the elements of informed consent for research involving repositories or retention of samples or data, when applicable
  - Section 10.1.1.2.9: clarifying that the plans for managing conflicts of interest as described in this section apply to non-ceded studies
  - Section 10.2.1.6: clarifying that the IRB Director’s determination of convened vs. expedited review is only mandatory for research with the sole purpose of establishing a repository
  - Section 10.2.4.2.2.2: adding that research in exempt categories (9), (10), (12), and (13) may involve the retention of samples or data for extra use by the study investigator(s) or by other investigators
  - Section 10.2.4.1: clarifying when amendments must be submitted for exempt research
  - Section 10.2.5.1: clarifying when recipient investigators are conducting human subjects research
  - Section 13: adding a definition for “Repository”

Revisions approved 6/22/21

- Sections dated 6/22/21 - minor corrections, consistency changes, and clarifications, and in addition:
  - Section 7.2.2.14.5: adding that for single-site, investigator-initiated clinical trials, the investigator must indicate which service was used to obtain data demonstrating the feasibility of fulfilling sample size enrollment
  - Section 8.4.5.3: clarifying that when the contracted interpreter telephone line is used, the interpreter ID number may be recorded on the witness signature line

- Section 10.2.5.2.2: modifying the quality improvement/quality assurance criteria to reduce redundancy and improve clarity
- Section 12.1.2: clarifying that the IRB's determinations regarding IND Exemptions are documented in the electronic system if reviewed via the expedited procedure, or in the IRB minutes if reviewed at an IRB meeting

Revisions approved 10/02/21

- Section 2.5.4: Adding a requirement to submit a Final Report after the IRB of record closes the study
- Section 5.7: Clarifying that the Chair who conducted the meeting is the one who electronically signs the minutes for that meeting
- Section 7.2.2.14.5: Modifying the date of compliance with the new sample size question for single-site, investigator-initiated clinical trials
- Section 9.5.2: Clarifying that for minimal risk research involving decisionally-impaired persons that uses consent via next of kin, the IRB does not need to make a formal waiver of consent determination
- Section 10.2.4.3: Clarifying that there is no requirement for the IRB to review translated abbreviated consent language and other translated materials for exempt research
- Section 10.2.7.2: Modifying the content of final report letters, and removing the requirement to issue a final report outcome letter for exempt and ceded research
- Sections 11.2.2, 11.3.2, 11.3.4, 11.3.5, 11.3.6, 11.3.7, 11.3.8, 11.3.9.1, 11.3.9.2, 11.3.9.3, 11.3.10, 11.3.11: Clarifying oversight activities for ceded research, modifying time lines related to oversight activities, adding procedures for remote monitoring activities, and clarifying minor inconsistencies and omissions in oversight policies that have been identified during the usual practice of these activities
- Section 12.1.4: Adding a new policy for use of drugs and biologic products from the CDC Drug Service

Revisions approved 10/27/21

- Section 7.2.2.1: Adding Section 7.2.2.16.2 as information that could be collected in the exempt review path
- Section 10.1.1.2.9: Clarifying that management plans for studies not ceded to a reviewing IRB will be reviewed and approved at a convened meeting by a separate vote

Revisions approved 1/29/22

- Section 6.6.9: Standardizing the determination for who is the responsible party (RP) for clinical trials registered on ClinicalTrials.gov, and other minor language and formatting edits
- Section 7.2.2.6.5: Clarifying when submission information about screening procedures is required
- Section 7.4.1.1: Adding the option to use an electronically signed PI responsibilities attestation
- Section 10.2.3.1.1: Adding a new billing arrangement requirement for ceding to a commercial IRB, and updating the policy description of the cede outcome letter
- Section 10.2.4.3: Adding the requirement to track whether subjects agreed to optional retention of samples or data for extra use in exempt research
- Section 13: Modifying the definition of repository to clarify that it applies to research using identifiable data or identifiable biological samples

Revisions approved 2/15/22

- Sections dated 2/15/22 - minor corrections, consistency changes, and clarifications, and in addition:
  - Sections 2.5.4 and 10.2.3.1.1: Adding a requirement that the study team report to the Boston Medical Center and Boston University Medical Campus IRB any serious and/or continuing noncompliance determinations made by the reviewing IRB in relation to event(s) that occur at the Boston Medical Center or Boston University Medical Campus site.
  - Section 6.6.9: Clarifying that BMC and BU Medical Campus will not register a study on ClinicalTrials.gov unless the PI is the sponsor, and/or BMC or BU Medical Campus is the prime awardee of external funding, or BMC or BU Medical Campus is considered the 'main site' in a multi-site study.
  - Section 7.2.2.20: Adding a requirement that any clinical trial that is multi-site or receives NIH funding must use a separate protocol

Revisions approved 5/22/22

- Sections dated 5/22/22 - minor correction, and in addition:
  - Section 4.3: Updating position title from IRB Coordinator to IRB Reliance Specialist
  - Section 5.1: Adding that IRB meetings may also be conducted using remote technology
  - Section 7.2.2.2: Adding new criteria for sign-off by Perinatal Research, and adding information about the requirement to include a description of the plan for initial and continuing training of inpatient and/or outpatient nursing staff
  - Section 7.2.2.6.5: Clarifying that a consent form meeting the criteria of Section 8.2 is required if the screening involves any clinical procedures or obtaining PHI directly from potential subjects unless the study qualifies for a waiver or alteration of authorization under Section 8.5.2.2.

- Section 7.2.2.14.1 and 7.2.2.20: Removing the collection of a description of the plan for inservice training of nursing staff from these sections, as this has been consolidated in 7.2.2.2.
- Section 7.2.2.16.4: Adding new questions to confirm that investigators will maintain a tracking system in order to document who opted in or opted out of future use of their samples or data, when applicable.
- Section 10.7: Clarifying HRPP reporting requirements when an external IRB of record determines that serious or continuing noncompliance and/or an unanticipated problem(s) has occurred at the BMC/BU Medical Campus site, and/or when an external IRB of record suspends or terminates approval at the BMC/BU Medical Campus site

Revisions approved 6/15/22

- Section 7.2.2: Adding a requirement to provide information regarding the commitment of nursing resources required to conduct the study and adding minor clarification about provision of BMC clinical services
- Section 7.2.2.10: Adding three new targeted populations (BMC inpatients, BMC outpatients, BUGSDM dental patients) to the Subject Populations Information
- Section 7.3.1: Adding a requirement that PIs must sign off on Reportable Event and New Information forms and clarifying that PIs do not need to sign off on requests that only involve changes to contact information or the submission of new or revised promotional recruitment materials

Revisions approved 8/27/22

- Sections dated 8/27/22 - minor formatting correction, and in addition:
  - Section 2.5.4: Adding a requirement that studies ceded to an external IRB must notify the BMC/BU Medical Campus IRB when changes are made to eliminate an apparent immediate hazard to subjects at BMC or BU Medical Campus (“internal immediate apparent hazards to subjects”)
  - Section 7.4.3.1: Revising the study status options at continuing review to be consistent with the wording used in the electronic system
  - Section 7.2.2.16.4: Removing an option from the electronic system that indicates that all samples or data will be completely de-identified (with no master-code/key) at the time they are retained, as this option would signify that the retention constitutes not human subjects research
  - Section 8.2.2: Clarifying that that investigator signature is required if the study is conducted under ICH-GCP and that that the posted consent templates contain the most recently approved version of the therapeutic misconception language
  - Section 8.4.1: Clarifying when the consent form does not need to be signed and dated by the person conducting the consent discussion
  - Section 10.2.3.1.1: Adding that the outcome letter for ceded research will include a reminder about the requirement to notify the BMC/BU Medical Campus IRB about changes made to eliminate an apparent immediate hazard to local subjects

Revisions approved 10/23/22

- Sections 1.1.1, 1.1.2, 5.2, 7.2.2.2, 7.4.1.2, 7.4.1.4, 10.2.6: Changing all references to “Boston University School of Medicine” to “Boston University Chobanian & Avedisian School of Medicine”
- Section 1.3.2.1: Revising some of the language in the questions included in the Principal Investigator Survey, and clarifying that this survey is sent to Principal Investigators after study approval or disapproval
- Section 6.6.5.2: Designating noncompliance with 21 CFR Part 11 requirements for electronic records and electronic signatures as a major deviation when compliance with 21 CFR Part 11 is the responsibility of the Principal Investigator per Section 12.4.7.
- Section 7.2.2.8.1 and 7.2.2.8.2: Adding a new question in the Drugs or Biologic Agents and Devices sections in the electronic system in order to capture when FDA-regulated studies propose to use a BMC or BU Medical Campus-managed electronic system for documentation of electronic records and signatures
- Section 7.2.2.16.6: Clarifying that when the BMC/BU Medical Campus IRB is the IRB of record for BU-CRC, a CRC site PI CV is not required if the only engaged investigators from BU-CRC are students obtaining academic credit for their engaged study activities

Revisions approved 12/18/22

- Section 6.6.1: Clarifying that as part of the PI Responsibilities, the PI needs to maintain study documentation that demonstrates compliance with the approved study application and/or protocol
- Section 6.6.5.2: Designating nonadherence with an IRB-approved or sponsor-required Corrective and Preventative Action plan as a major deviation

Revisions approved 4/21/23

- Section 2.3.1: Changing the IO for Boston Medical Center to the Vice President and Chief Scientific Officer
- Section 7.2.2.2: Modifying the special routing information to reflect changes in designated signatories (removing BCHCP routing, adding information regarding existing Radiation Safety routing, adding new

routing for MCSR Research Licensure, revising the description for routing for research in Pediatric clinical areas, and modifying the routing for studies that target BUSM or GMS students)
- Section 7.3.1: Removing the requirement that PIs must sign off on final reports in the electronic system
- Section 11.3.2 and 11.3.8: Revising the Important Finding category to include findings that might involve reporting to other Boston Medical Center or Boston University officials or committees as applicable
- Section 12.4.7: Narrowing the PI requirement to ensure compliance with 21 CFR Part 11 (when using a BMC or BU-managed electronic system) to apply to studies that are conducted under an IND or IDE or non-IND/IDE studies that involve data that will be submitted to FDA

Revisions approved 6/23/23
- Section 7.2.2.2: Modifying the special routing signatory for studies involving the targeted recruitment of SPH students
- Section 10.7: Adding the BMC Executive Director of Research Operations as a recipient for HRPP reporting of Unanticipated Problem(s), serious or continuing noncompliance, or suspension or termination of research, as applicable

Revisions approved 8/12/23
- Section 6.5.1: Adding an enforcement process for noncompliance with requirements for conflict of interest disclosure
- Section 6.6.8 and 6.6.9: Adding a requirement that departing PIs must consult with the PRS Administrator prior to leaving BMC/BUMC if they have an active study registered on ClinicalTrials.gov
- Section 7.4.4: Modifying closure reports for ceded research to add collection of study status, enrollment numbers, and demographics

Revisions approved 10/20/23
- Section 2.5.4: Removing the bulleted list of changes that require an amendment for ceded research, as the comprehensive list now appears in Section 10.2.3.1.2
- Section 6.6.8: Clarifying that requests to change the PI or Supervising PI are only reviewed by the expedited procedure for non-exempt research; requests to change the PI or Supervising PI for other types of research are administratively reviewed by an experienced member of the IRB staff
- Section 6.6.9: Clarifying that NIH-funded Basic Experimental Studies Involving Humans (BESH) that meet both the federal definition of basic research and the NIH definition of a clinical trial must also be registered on ClinicalTrials.gov before final IRB approval is issued
- Section 7.2.2.2: Adding a special routing sign-off for the Boston Medical Center Research Technology Program (RTP)
- Section 7.2.2.18: Updating the cede application to add the collection of three recruitment populations (Boston Medical Center inpatients, or Boston Medical Center outpatients, or Boston University Henry M. Goldman School of Dental Medicine dental patients), as well as whether the study requires nursing support
- Section 7.4.1.2: Updating the description of the amendment process to add ceded research
- Section 8.1.3.7: Revising the LIP definition to more closely reflect the definition in the BMC Medical-Dental Staff bylaws
- Section 8.4.1: Clarifying that when written consent is obtained, the subject must be given *or offered* a copy of the consent form, unless this requirement is specifically waived or modified by the IRB
- Section 10.2.3.1.1: Updating this policy section to match the information that is currently collected in the cede application
- Section 10.2.3.1.2: Clarifying when changes to the research plan in ceded research must be submitted as an amendment prior to implementation of the changes
- Section 10.2.7.1: Modifying this section to match the changes to Section 6.6.8, described above; clarifying when requests to change the PI or Supervising PI are reviewed by the expedited procedure vs administratively reviewed

Revisions approved 12/22/23
- Sections 2.5.2.1, 6.6.3.3, 7.4.5, and 10.2.1.5: Revising the type of safety monitors' report that needs to be reported using the Reportable Event and New Information (RENI) Form
- Section 7.2.2.4: Adding a question to the IRB application that requests confirmation that all listed investigators are up to date with the institutional Standard Operating Procedures (SOP) training, as required
- Section 7.2.2.18: Adding the collection of the IND or IDE for studies that propose to use a commercial IRB for industry-sponsored multi-site trials, and clarifying that the IRB application requests confirmation that the billing arrangement is set up so that the commercial IRB bills the sponsor directly for the IRB review costs
- Section 7.4.3.1: Updating the Progress Report for studies involving investigational drugs to add confirmation that the most recent version of the Investigator's Brochure has been submitted to the BMC/BU Medical Campus IRB

Revisions approved 3/11/24

- Sections 2.5.2.1 and 7.2.2.16.6: Adding a requirement that external sites requesting to rely on the BMC/BU Medical Campus IRB must sign an indemnification provision
- Sections 6.6.6, 6.6.8, 7.7.4, and 10.2.4.1: Modifying study closure requirements to permit PIs to close exempt studies without the need for submission of a Final Report
- Section 7.2.2.16.6: Adding a description of the study activities being conducted by the relying institution(s) to the electronic application

Revisions approved 4/26/24

- Sections 7.4.3.2: Modifying the submission information for study status check-in for studies given an exempt determination without an expiration date and for studies ceded to another IRB
- Sections 7.4.4: Permitting PIs to close ceded research using the Status Check-In Report form
- Section 10.2.5.1: Revising the requirement to submit studies involving the use of publicly-available data to the IRB by limiting this requirement to studies that use publicly-available information about individual persons

Revisions approved 6/28/24

- Sections 2.5.3.2, 5.7, 7.2.2.10, 9.4.1, 9.4.2, 9.4.3, 9.4.4, 9.4.5, 9.4.7, 9.4.8, 9.4.9, 10.5.3, 12.8, and 12.10.10: Changing references to “pregnant women” to “pregnant persons”, along with similar gender-neutral changes (such as “both parents” in lieu of “mother” and “father”)
- Sections 3.2: Modifying the description of the IRB board composition to indicate that the boards include members of all genders
- Sections 7.2.2.10, 7.2.2.12.6, 7.2.2.18, 7.4.3.1, 7.4.3.2, 8.4.1, 8.4.5.1, 8.4.5.2, 8.4.5.3, 10.1.2, 10.1.3, 10.2.3.1.1, 10.2.3.1.2, and 10.2.4.3: Changing references to “non-English speaking subjects” to “subjects with limited English proficiency”
- Section 8.4.5.2: Removing the requirement that the person obtaining consent sign the non-English short form
- Section 10.2.4.2.1.2 and 10.2.4.2.2.2: Clarifying that the prisoner requirements do not apply to research in exempt categories (4), (9), (10), and (11), if the research is aimed at involving a broader subject population that only incidentally includes prisoners

Revisions approved 9/26/24

- Section 2.3.3.2: Updating the information regarding backup and recovery of the electronic system to match current processes

Revisions approved 10/29/24

- Sections 2.5.4, 6.6.3.2, and 10.2.3.1.1: Changing reporting requirements for Unanticipated Problems (UPs) in multi-site research where an external IRB is the IRB of record
- Section 7.2.2.15: Correcting a typo in the title
- Section 7.2.2.16.1: For international studies with local IRB approval and translated materials, requesting confirmation that the local IRB will review and approve accurate translations of the English materials (in lieu of the BMC/BUMC IRB)
- Sections 7.4.1.2 and 7.4.1.4: Harmonizing our policies regarding review of recruitment materials with the updated policies from the BUMC Communications/Marketing Offices
- Sections 7.4.3.2 and 7.4.4: Due to issues it would cause with reporting, reverting back to a prior policy by requiring submission of Final Reports to close ceded studies
- Section 8.4.5.1: Modifying the requirements for submission of translated materials to remove the requirement for submission to the BMC/BUMC IRB if the international local IRB will review and approve accurate translations of the approved English materials
- Section 10.2.4.1: Adding other changes made to exempt studies that require review by the BMC/BUMC IRB prior to implementation
- Section 11.4.3.2: Narrowing this particular section to only refer to potential research noncompliance evaluated by QA staff and modifying certain terms (such as “QA staff”) to align with other sections
- Section 11.4.3.3: Permitting experienced IRB staff to determine that a report of potential noncompliance is researcher noncompliance that is neither serious nor continuing, and to approve the associated Corrective and Preventative Action Plan

Revisions approved 3/2/25

- Section 5.7 and Section 10.2.1.1: Revising the procedure for IRB review of meeting minutes and clarifying when minutes are provided with the convened IRB meeting materials
- Sections 7.2.2 and 7.3.2: Removing references to the Reducing Implicit and Explicit Bias in Research form process
- Section 7.2.2.8.1: Updating the Drug and Biological Agents section to collect information on Drug Schedule (I-VI)
- Section 7.2.2.20: Requiring a separate protocol for studies that are required to post results on ClinicalTrials.gov

- Section 8.4.6: Permitting family members to serve as impartial witnesses to the consent process for enrollment of limited- and non-readers, and re-organizing this section for clarity
- Sections 10.1.3 and Section 10.2.2.4.3.2: Deleting these sections, as the processes described in these sections (review of status check-in reports for studies approved without an expiration date) are being moved to new Section 10.2.7.3.1
- Section 10.2.3.1.2: Requiring cede amendments for changes to template institutional-specific consent language, or consent language previously approved by a special routing signatory or entity, and removing information on the evaluation of status check-in reports for ceded studies as it now appears in new Section 10.2.7.3
- 10.2.4.5: Removing information on the evaluation of status check-in reports for research given an exempt determination on or after January 21, 2019, as it now appears in new Section 10.2.7.2
- Section 10.2.7.3.1: Adding a new section that describes the review of status check-In reports for research approved without an expiration date. This new section harmonizes information from previous sections 10.1.3 and 10.2.2.4.3.2
- Section 10.2.7.3.2: Adding a new section that describes the review of status check-in reports for studies given an exempt determination on or after January 21, 2019, using information previously included in 10.2.4.5
- Section 10.2.7.3.3: Adding a new section that describes the review of status check-in reports for ceded studies, using information previously included in 10.2.3.1.2
- Section 11.3.8: Clarifying how to resolve disagreements between the PI and QA staff regarding the classifications of findings
- Section 11.3.9: Revising the process that ensures reportable findings are submitted accurately to the reviewing BMC/BUMC IRB

Revisions approved 5/3/25

- Section 2.7.1: Adding a description of the monitoring and tracking of participant outreach to the IRB.
- Section 2.7.2: Adding a description of how the organization conducts activities designed to enhance understanding of human research by participants, prospective participants, or their communities, when appropriate

Revisions approved 9/23/25

- Section 7.2.2: Adding a sign-off process for BMC Clinical Research Unit, and modifying the wording in the BMC Nurse Scientist special routing question

Revisions approved 12/5/25

- Sections 8.4.5, 8.4.5.1, 8.4.5.2, 8.4.5.3: Reorganizing the policies related to the inclusion of subjects with limited English proficiency, and allowing public posting of the short form consent templates
- Section 10.2.1.1: Removing the inclusion of the panel packet as a mandatory element of materials provided to the IRB board prior to the meeting

Revisions approved 12/22/25

- Section 2.5.2.1: Permitting BU-CRC students who are receiving academic credit to be added as internal study personnel (with IRB oversight for BU-CRC covered under a global reliance agreement)
- Section 6.1.3.4: Clarifying that the cede requests referenced in this section apply if the external student or trainees are the Principal Investigators
- Section 7.2.2.16: Removing reference to CRC students from this section about external sites
- Section 10.2.3.1.1: Removing formal Chair review from the evaluation of initial requests to cede review
- Section 10.7: Updating the list of recipients who receive reportable event notifications

Revisions approved 2/24/26

- Section 1.1.2: Extending BMC/BU Medical Campus HRPP oversight to Boston Medical Center Brighton and Boston Medical Center South
- Section 2.3.1: Updating Institutional Official role designations
- Section 6.6.5.2 Adding ClinicalTrials.gov results posting noncompliance as a major deviation
- Section 6.6.9: Removing references to registering NIH-funded Basic Experimental Studies Involving Humans (BESH) on ClinicalTrials.gov
- Section 7.2.2.11 Adding a statement that reflects the language that is included in the consent form when participation in the study may trigger reporting to the IRS (>$2,000 in a calendar year)
- Section 7.4.4: Requiring confirmation that research activities have ceased at all relying sites when closing studies, and requiring site closure letters from the reviewing IRB for ceded research closures
  Section 10.2.5.3: Removing the requirement to submit the parent grant of a training grant for IRB review

Revisions approved 5/26/26

- Section 2.5.2.1: Adding an exception to the indemnification signature for collaborative research between CRC and BUMC
- Section 2.5.2.2: Clarifying that a cede review submission is not required for BUMC->CRC collaborative research covered by the global reliance agreement

- Section 2.5.2.3: Establishing a new section to describe the existence of the global reliance agreements between BMC, BUMC, and CRC
- Section 7.2.2.2: Adding an additional special routing question for studies that use, develop, or test artificial intelligence (AI), machine learning (ML), or large language models (LLMs) at any point in the research
- Section 7.2.2.12.6: Clarifying the submission requirements for subjects with limited English proficiency to distinguish between anticipated and unanticipated languages. Principal Investigators must identify languages in which they anticipate enrollment so the IRB can determine whether full translation is required, but are not required to specify languages for unanticipated short form use
- Section 7.2.2.18: Noting that the standard cede review submission is not required for BUMC→CRC studies covered by the global reliance agreement
- Section 8.4.5.2: Simplifying the short form consent documentation workflow by removing the requirement for a separate attestation form and removing the requirement for a separate signature page to be attached to the English narrative. Adding a usage cap of three uses of the short form per language per study before full translation is required, with a risk-based distinction. Streamlining the language approval process so that all languages for which the IRB maintains a pre-translated short form are pre-approved for use, with the ability for the IRB to exclude specific languages when enrollment of subjects speaking those languages is anticipated. Adding a cover page with instructions for the research team to each short form consent document
- Section 8.4.5.3: Clarifying the witness requirements when using the short form to explicitly state that the witness must be fluent in both languages
- Section 10.1.2: Updating the continuing review language to reference the 3-use threshold and greater than minimal risk translation requirement established in Section 8.4.5.2

Revisions approved 7/20/26

- Section 6.6.3.3: Modifying the time for IRB notification to clarify that the report must be made as soon as possible, but no later than 7 days after the investigator or research staff member receives the report from the safety monitoring body.
- Section 6.6.5.2: Incorporating the same clarification regarding reporting major deviations as soon as possible, but no later than 7 days. Broadening the ClinicalTrials.gov major deviation criterion to encompass all noncompliance with the registering, updating, or posting requirements for clinical trials on ClinicalTrials.gov, not just results posting. Adding a new major deviation criterion for privacy incidents.
- Section 7.2.2.2: Adding a question identifying the Home Institution of the Principal Investigator. Clarifying that features requiring special routing may vary by home institution. Adding a new special routing sign-off question for studies involving investigators outside of Boston Medical Center accessing or using data or biological samples derived from BMC patients.
- Section 7.4.6: Establishing an 18-month administrative closure window for Review Responses pending on the study team side.
- Section 10.2.4.2.2.2: Clarifying that in order for a study to qualify for exemption under category (13), the adult subjects must have the capacity to consent for themselves.
- Section 11.3.8: Modifying the process for reporting privacy incidents identified during Audits and QA reviews to have the QA staff directly notify the appropriate Privacy Officer(s) as well as BU IT (if the incident involves a security issue).
- Section 11.3.9.3: Deleted this section, as it is no longer relevant.
- Section 11.3.10: Clarifying that QA reviews are provided to the BMC Research Compliance Officer if the study involves Boston Medical Center patients or resources.
- Section 11.4.3.3: Adding reporting to BU IT at ithelp@bu.edu, if the incident involves a security issue.
- Section 11.4.3.4: Adding reporting to BU IT at ithelp@bu.edu, if the incident involves a security issue.

Revisions approved 9/16/26

- Sections 2.5.4, 6.6.2.1.5.2, 6.6.3.2, 6.6.3.3, 6.6.5.2, 10.2.1.5, 11.3.8, 11.3.9.1, 11.5: Standardizing the reporting and response timeframe used throughout the HRPP Policies and Procedures from "7 days" to "7 calendar days"
- Section 7.2.2.6.5 and 8.1.3.4: Removing references to requiring a full consent meeting all required elements when the screening involves obtaining PHI directly from subjects
- Section 7.2.2.11: Revising to account for the roll-out of the new BU third-party payment system, which requires collection of SSN/ITIN and bank account information for any amount of subject payment
- Section 7.3.3: Revising language to reflect move to concurrent ancillary department sign-off and IRB review
- Sections 10.2.4.2.1.2 and 10.2.4.2.2.2: Clarifying that studies can qualify for exemption even if they mix and match from equivalent protections exempt categories and Common Rule exempt categories (provided the activities fit only in these two sets of exempt categories)