

Response to FDA from FACIT.org (David Cella)

This public response forum is a useful venue to clear up some apparent misperceptions about the FACT and FACIT measures with regard to the FDA PRO draft guidance. Thank you for this opportunity.

The draft guidance articulates several opinions that relate to FACIT questionnaires and bear clarification. We hope the reader of this comment will consider the following “facts about the FACT” and disseminate through the agency to avoid future misunderstanding. Specifically:

- “FACT” stands for Functional Assessment of Cancer Therapy.
- “FACIT” stands for Functional Assessment of Chronic Illness Therapy.
- Every subscale developed under the FACT/FACIT name was developed with patient input. This has been a defining hallmark of FACT/FACIT
- Every scale was developed with a keen eye to content validity, with the major departure from the FDA Guidance being that the content validity approach espoused by the guidance is conceptual, and that of the FACIT is *primarily empirical and secondarily conceptual*. We know of no study that has ever proven a conceptual approach is scientifically superior to an empirical one. Empirical approaches (starting from the criterion group and building up without a pre-conceived idea of concepts) pre-date FACT/FACIT development by 30 years, and have worked well over that time.
- The FDA focus on the label is understandable based upon its charge, but the harshly-detailed focus of section IV in the guidance threatens to disable the field. Often a FACT questionnaire is proposed to the FDA as the best available -- or among the best available -- measure of a concept that patients have identified to be important. Flexibility in “naming” concepts that emerge from proven instruments like FACT/FACIT is strongly encouraged in reviews going forward. For example, many FACT/FACIT scales aggregate the “most important symptoms or concerns” of a patient group under study. This is not “all” important concerns... PRO measurement can never accomplish that. “Most important concerns” and “Most important symptoms” are “label-worthy” concepts, especially since they come from the patient. Patient interviews at the front end of FACT development, and follow up interviews more recently, reassure us that we are asking the right questions. When interviews tell us otherwise, we modify the questionnaire and proceed with improved measurement. This iterative process of revising FACT/FACIT scales has defined our 17 year history. We can always do better, but must settle for the best available when the ideal is beyond reach.
- In collaboration with the National Comprehensive Cancer Network (NCCN), we are completing a major project that should satisfy many of the concerns expressed in the draft guidance. We are asking patients with 11 different types of advanced cancer to help us prioritize the questions on the FACT questionnaire that corresponds to their primary site. The symptom indexes that this process creates will thereby reflect the most important symptoms or concerns of people with their particular cancer. We will further work to determine the extent to which experts

- consider these most important symptoms to be attributable to disease or treatment, a further step toward justifying a label claim related to one or the other.
- A final issue in the guidance relates to item weighting. No study has ever shown that weighting items produces substantively different results than simple summation. We employ simple summation, but at times “load in” items with overlapping content in areas where patients and experts place considerable emphasis. For example, across most solid tumors, patients and experts stress the importance of pain and fatigue. If only one question on pain, and another on fatigue, are included along with several others asking about less-important symptoms, those lesser symptoms will carry equal weight in the simple summation score. To adjust for this, we often introduce more than one question in a high importance symptom area in order to better represent the relative importance weights given by respondents in instrument development. This approach avoids the problems of assigning relative weights to individual responses, and has the added value of enhancing the internal consistency of the summated index, while also making it more representative of patient priority.

In conclusion, the FACT/FACIT stand up very well in terms of compliance with guidance, and yet there are focal concerns raised by the guidance that impede our ability to use any number of instruments (virtually all instruments, FACT included), which is a great disservice to the patients, and the general public, we are here to serve.

We welcome you to visit www.facit.org for further information.

Sincerely Yours,

The staff at FACIT.org