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DEPARTMENT OF HEALTH AND HUMAN SERVICES
FOOD AND DRUG ADMINISTRATION

HEALTH PROFESSIONAL ORGANIZATION MEETING

Tuesday, September 8, 1998

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1 P R O C E E D I N G S

2 **Welcome and Introduction**

3 MS. HOLSTON: Good afternoon. We are going to get
4 started now. Thank you all very much for coming.

5 It is my pleasure once more to welcome many of you
6 to another of FDA's meetings with health professionals. We
7 hold these meetings on a quarterly basis.

8 I am Sharon Smith Holston, FDA's deputy
9 commissioner for External Affairs, and I usually have the
10 pleasure of opening these meetings and welcoming you.

11 It is an opportunity for us to keep you informed
12 about things that are going on that are of real significance
13 and importance to FDA, and usually to answer your questions
14 and to get your viewpoints about things that are happening
15 in our various positions or various proposals.

16 I think today's meeting is doubly special, not
17 only because it is part of an important requirement of the
18 FDA Modernization Act of 1997--and trust me, this is a law
19 that is having a profound impact on the agency and its
20 future--but, also, this meeting is kind of special because
21 it involves a reversal of the customary roles that we have.

22 Usually, it is FDA and we have a panel of
23 presenters up here discussing new processes or new proposals
24 and new developments in the agency and answering your
25 questions, but, today, we are going to be hearing from you,

1 from representatives of health professional organizations
2 and other organizations responding to our questions and
3 offering advice to us on how the agency can maximize the
4 effectiveness of our efforts to meet all of the multitude in
5 responsibilities that we have under the Federal Food, Drug
6 and Cosmetic Act.

7 As you are going to hear later in a little more
8 detail, this consultation today is part of an agency-wide
9 inquiry into the views and preferences of our constituents,
10 as we seek to develop and we are committed to carrying out a
11 strategic plan that has to be submitted to Congress and
12 published in the Federal Register by late November.

13 Fulfilling this mandate is part of the FDA
14 Modernization Act, and it is described in Section 406(b).
15 It really is one of probably the most taxing projects that
16 the agency has ever faced. I think because it is such a
17 monumental task and because it requires really just the
18 highest level of leadership and expertise in order to
19 accomplish it, I think we are very fortunate today to have
20 with us two senior FDA managers who are extraordinarily well
21 qualified to discuss both the purpose of the meeting and the
22 process that we are engaged in and the plan as it will be
23 developed.

24 So we have with us today--and I feel very proud to
25 be able to introduce--Dr. Michael Friedman who is the acting

1 is so limited that very important, very thoughtful decisions
2 need to be made.

3 This is an invitation today not just for you, but
4 for all the other groups that we are meeting with, to please
5 help us engage in that very important activity, choices,
6 opportunity selection, lost opportunities, but also how to
7 do what it is that we wish to do.

8 Now, this is the fifth such meeting that has been
9 held. There will be others. You will be told later about
10 electronic site or posting to us specific thoughts, ideas,
11 suggestions. Of course, those will be welcomed in a more
12 standard written format as well, should you wish to engage
13 us in that way.

14 We are talking about this as an episode today, but
15 let me make clear that this is really an ongoing activity.
16 It is an activity that we will engage in essentially forever
17 because we will need to make these sorts of choices forever.

18 The discussions today will partly revolve around
19 budget, but these are not budgetary discussions. These are
20 really choice discussions. These are really strategic
21 discussions, and that, I think, is the way we should look at
22 it.

23 As Sharon has mentioned, we do take very seriously
24 the FDA Modernization activity. This is an important
25 component of that. This, such as all the other aspects of

1 the Modernization Act, we are deeply committed to fulfilling
2 in a timely and appropriate manner.

3 In order to set the framework for our discussions
4 today, let me share with you some simple facts that probably
5 everyone here is aware of, but I hope to be able to help
6 frame the discussions that will follow after me.

7 If I could get someone to please turn on the
8 projector, I would be very grateful. I do not think it is
9 on. Just the power button on the side. Thank you.

10 I do not know if that is seeable or not. It looks
11 as though this light may be shining on it, but let me tell
12 you what this is. I think it is important for you to
13 understand the rising workload that the FDA has been
14 managing and will continue to manage in the future.

15 If one considers the range, the basket of all
16 kinds of applications that we are asked to review--and these
17 are new product applications. It does not list our work
18 involved for inspections or other sorts of very important
19 activities, but if one simply looks at the volume of new
20 applications that we see every year, it has been increasing,
21 and it will continue to increase, we predict, 12 percent per
22 year.

23 That means that our workload doubles every 6
24 years. It is a phenomenal robustness. It is testimony to
25 the great investments and the great intellectual vigor of

1 industry, of academia, of some of our Federal agencies, and
2 more about that later, but this is the background upon which
3 our activities are proceeding.

4 At the same time, because of the very successful
5 efforts that have been made by our center directors, a huge
6 credit needs to go to them for their very ingenuous and very
7 hard application of process reforms. While our workload has
8 been increasing by 12 percent, our productivity has actually
9 been increasing by 17 percent.

10 The explanation of the difference of those figures
11 is that in the early 1990's, there were backlogs. There
12 were uncompleted activities that needed to be reduced,
13 hence, the apparent increase in productivity compared to
14 outputs.

15 If one looks at our budget during that time, the
16 agency has both been very fortunate in that we have had a
17 relatively stable budget during that time, and our
18 appreciation must be expressed to our appropriations and
19 congressional leaders for their role in this, to the
20 administration for its support in this regard, but please
21 note that at a time of increasing work, our budget was, for
22 all practical purposes, flat and, as I will show you in a
23 moment, actually declining.

24 This is a rather busy display. Let me walk you
25 through it, if I may.

1 By all appearances, from 1993 to 1999--and I think
2 this number is not yet defined for this year, but probably
3 will be where the little red dot is, if my palsy will keep
4 it there--right above 1.0- or \$1.1 billion, there certainly
5 appears to be an increase during that period of time.

6 If one subtracts from that inflation erosion the
7 cost, you will see that the actual dollars that one has
8 because of cost increases, mostly increases in personnel
9 cost, reduces that substantially.

10 Clearly, this is an erosion that every Federal
11 agency faces, and we are not at all unique in that. We
12 expect that, and nor are we complaining about that, but
13 please note this purple area which represents something that
14 is different.

15 These are priority programs which have been
16 specifically segregated, if you will, by Congress, by the
17 administration. Located here are the PDUFA, the
18 Prescription Drug User Fee activities, the mammography
19 quality assurance activities, tobacco, the food safety
20 initiative, dollars that are requisitioned, dollars that are
21 segregated according to a specific activity and cannot be
22 used for anything else.

23 So these represent a real increase in the program,
24 but this is not a pool of money which is missable with the
25 other activities within the agency.

1 What we actually see is that there is a shrinkage
2 in this portion of the agency, and think for a moment what
3 activities reside within this pool, our generic drug
4 activities, our device activities other than mammography
5 quality assurance, our veterinary products. Think of the
6 non-food safety food activities, whether it is food
7 additives or other kinds of very important activities that
8 they are engaged in. Think about our scientific
9 infrastructure, our laboratories, our scientists. Think of
10 our statistics in epidemiology, our adverse event reporting
11 system. Think about our inspectional activities, our
12 compliance activities.

13 One could argue that what is here in this
14 component of the agency is a vast amount of what we do. It
15 is a vast amount of what the public expects us to do, and it
16 is coming at a time of shrinking resources, when the
17 workload in this area is growing very, very vigorously.

18 Certainly, these programs are some of the most
19 important to the agency. I think we have done a really
20 splendid job with these. I am very proud of what the agency
21 is doing in this regard. I think this is a fabulously good
22 investment, but I suggest to you that the reason you are
23 being asked to help us is to talk about how best to manage
24 that portion of the portfolio.

25 This simply shows the constant dollar relative to

1 increasing workload. You can see, in much the same way, we
2 have this unfunded wedge of activities which grows larger,
3 and that is why it is essential. Even if 406(b) never
4 existed, we would be holding this meeting. We would be
5 asking you in the same very serious way to please offer us
6 your best advice and your best thoughts.

7 Let me make one final observation, if I may. This
8 country has been very fortunate in that our congressional
9 leaders and the administration have recognized the fabulous
10 value that we as citizens get from investing in the National
11 Institutes of Health.

12 There has been no better investment made by our
13 country, I argue, than the investment at NIH. The budget
14 has gone up very dramatically. So it is now above \$13.5
15 billion. Were FDA displayed upon this access, we would be
16 here.

17 My question to you is: Since this has been the
18 engine of so much biomedical research success, since
19 investments made at NIH, in academia, and the R&D work which
20 has been invested by the industry, now greater than \$21
21 billion, when you consider that those investments are
22 likely, that they are expected to produce products that we
23 will have the fortune to review as an agency and which we
24 all as citizens will have the fortune to be able to use as
25 we get older and more infirm, this is a fabulous investment,

1 but it means that the agency will be facing even greater
2 challenges in the future to deal in a timely way with more
3 innovative products, more variety of products, and just a
4 sheer greater mass of products.

5 We need your help very much. We value your
6 insights and the collaborative role in which we will work
7 together on this with.

8 Again, I appreciate your taking time from your
9 busy days to be here with us. I want to thank you for
10 engaging with us seriously in this, and let me assure you
11 that we will listen very hard to the advice and suggestions
12 that you offer.

13 Thank you all very much.

14 **FDA Plan Development**

15 MS. SUYDAM: Good afternoon. I am Linda Suydam,
16 and I am the associate commissioner for Strategic
17 Management. I think Dr. Friedman has done an excellent job
18 in describing the context in which FDA is now doing the
19 406(b) plan.

20 My job today is to tell you what we are going to
21 do and how we are going to do it and how we need to have
22 your help.

23 The FDA Modernization Act, which passed in
24 November of 1997, mandated that FDA consult with its
25 appropriate stakeholders, and it defines stakeholders, as

1 you see on the slide on the screen.

2 This is not something that is unusual for FDA
3 because we have been consulting with groups like this on a
4 regular basis, but for the first time, Congress has mandated
5 that this be a part of the activity in developing the 406(b)
6 plan.

7 In addition to that, Congress suggested that the
8 plan would have six objectives. I think the six objectives
9 relate specifically to the kinds of things that Congress was
10 looking for the agency to move forward and do in the future.

11 The first two of the six are to maximize the
12 availability and clarity of information about the process of
13 review applications and submissions. One of the things that
14 we have heard in the five stakeholder meetings that we have
15 had to date as a recurring theme is that more and more of
16 our constituents are asking us to have transparent processes
17 so that they know what it is that is expected of them. Our
18 plan will lay out how we intend to do that. We cannot do
19 that unless we have input from people in meetings like this.

20 The second is to maximize the availability and
21 clarity of information to consumers and patients about new
22 products, and this is another aspect of providing
23 information to our stakeholders, but in this case, providing
24 information about specific products, not processes.

25 The next two objectives relate to implementing

1 inspection and post-market monitoring provisions of the Act
2 and assuring that we have scientific and technical
3 expertise. We have heard so far in the meetings that we
4 have had how important it is to have the post-market piece
5 that matches with the effort that we have been placing on
6 the pre-market activities in the last 5 years.

7 Certainly, everyone is asking that the FDA
8 maintain its scientific and technical expertise, and we are
9 asking today if, in fact, those are things that you think
10 are as important as well.

11 The final two are to give us specific time frames.
12 The first is to establish mechanisms for meeting the
13 establishment of time periods for the review of all
14 applications and submission, and the final is to really get
15 rid of all the backlogs by January of the year 2000.

16 We think that the activities of the agency, in
17 addition to meeting the objectives laid out in 406(b), can
18 also be described in areas of concern that we have outlined
19 in the message that was put forward on our web page in our
20 issues of concern that are facing the agency today.

21 Three of those issues are adverse event reporting
22 and injury reporting--and I think that one particularly may
23 affect this group. And you may want to comment on FDA's
24 activities related to this area of our statutory workload.

25 Our product safety insurance, we have, as Dr.

1 Friedman mentioned, spending--we are spending less time,
2 less money, less resources on our product safety activities,
3 and we want to know what is the appropriate level.

4 And then product application reviews cannot be
5 neglected. We have to continue with improving those
6 processes and continuing with the efficiencies that we have
7 already started.

8 Then, finally, we have four activities that have
9 been highlighted in our budget that are, in some ways,
10 different than the other activities. One is food safety,
11 which is a Presidential initiative. The second two,
12 outreach and scientific infrastructure, speak specifically
13 to the objectives in 406(b).

14 Then the final is tobacco, which is also a
15 Presidential initiative, and which we will see if the courts
16 will allow us to continue with that process, but at this
17 point in time, it is a high-priority activity for the public
18 health of this Nation.

19 Finally, I would like to mention to you that there
20 is an open docket that we are asking for comments. The
21 docket number is shown on the screen. This docket will
22 remain open until September 21st. We have another public
23 meeting scheduled for September 14th. That will be the last
24 of the stakeholder meetings in this series of meetings.

25 We do have a deadline to have the 406(b) plan to

1 Congress by November 21st. We are hoping to be able to
2 compile your comments and concerns, and filter those into
3 the document that we plan to send to Congress.

4 You can comment three ways. You can comment by
5 regular mail, and there is the address. You can comment by
6 3-mail, or you can comment via the web. All of those are
7 valid and will find their way into the official docket.

8 We expect that this year, it will be a
9 particularly difficult process, since we have never done
10 something like this, to put together this plan. We hope
11 that in the future, we continue to have the kind of support
12 that we have had at meetings like this because we intend to
13 continue this process, and we hope to have stakeholder
14 meetings in the spring next year, so that we can, in fact,
15 have a little more time to put together a thoughtful revised
16 plan for the following year.

17 So I look forward to hearing your comments today,
18 and we look forward to hearing from you via the docket.

19 Thank you.

20 **Common Themes from Center Stakeholder Meetings**

21 MS. HOLSTON: Thank you very much, Mike and Linda.

22 Now, before we introduce our panels and start the
23 discussion, I thought it would be helpful if I took just a
24 few minutes to give you some very preliminary impressions
25 from the stakeholder meetings that were held last month by

1 our five product centers, and that is the Center for Drug
2 Evaluation and Research, the Center for Biologics Evaluation
3 and Research, the Center for Devices and Radiological
4 Health, the Center for Food Safety and Applied Nutrition,
5 and the Center for Veterinary Medicine. Each of those
6 centers held a specific stakeholders meeting.

7 I said our preliminary findings from these
8 meetings because the meetings, although they were extremely
9 well attended and people were well prepared, did take place
10 in the middle of August at the height of the vacation
11 season, and not all of the stakeholders who would have liked
12 an opportunity to participate were able to come and to
13 address the questions as fully as they wished.

14 Therefore, we do expect to receive additional
15 responses in writing, and as you saw, on the screen by
16 e-mail, either by letter or over the Internet. All the
17 information you need, if you would like to use one of those
18 methods, it is in the packet that you have.

19 Of course, in addition, we are looking forward
20 with a great deal of anticipation to what we are going to
21 hear from stakeholders in this meeting.

22 Finally, there is a major meeting, agency-wide
23 meeting, scheduled for September 14th, and that meeting is
24 going to be covered live on the Internet as well, all of
25 which is to say that any observations I make today about

1 what we have learned, I can only say, thus far, are still
2 tentative.

3 So, with that in mind, one general statement I am
4 happy to make is that most of the stakeholders are
5 responding to our request exactly as we would have hoped
6 they would. They have been very candid. They have been
7 very well informed, and they certainly have been very
8 well-intentioned in providing us with feedback.

9 The presentations frequently reflected a real
10 appreciation for the challenges that confront the agency.
11 Some of the spokesman, in fact, frankly admitted that they
12 have absolutely no idea how our huge obligations and our
13 limited resources could be brought into harmony.

14 As one presenter at the meeting of the Center for
15 Veterinary Medicine put it, it is real easy for all of us
16 stakeholders to stand up here and look across the fence and
17 tell our neighbor how to raise their kids, when, in fact,
18 these people are on the firing line and need all the help
19 that we can give them, a statement which we appreciated a
20 lot.

21 Another stakeholder, equally forthrightly, started
22 his presentation by saying, "I wish I could say that we come
23 here with some magic bullets and solutions for what the
24 center is encountering. I hasten to say from the very
25 beginning that we have none."

1 But we also heard from many stakeholders who told
2 us emphatically and felt very strongly about what we should
3 be doing. Frequently, this included getting more money from
4 Congress, something that really has not been a viable option
5 for us in recent years, and then spending it on projects
6 that rather understandably were of particular interest to
7 the speaker or her particular organization that they
8 represented.

9 The proposals on this very long and frequently
10 very detailed wish list of our stakeholders cover just about
11 every aspect of FDA's operations.

12 To mention just a few of the efforts which we were
13 urged to focus more resources, they included fighting
14 economic fraud and mislabeling of products, faster approval
15 for petitions, creating an Office of Drug Safety, require
16 the new inspection system on certain fishing vessels, giving
17 top priority to the surveillance of cosmetics, funding more
18 contracts with the States, and even adding trans-fat to the
19 nutrition label.

20 It added up to a real cornucopia of proposals and
21 ideas, many of which, if the circumstances were such that we
22 had a lot more money at our disposal, would probably be
23 deserving of being put into practice.

24 As could be expected, given our diverse
25 constituency, some of the views that were expressed at the

1 meetings were diametrically opposed to each other.

2 For example, at the meeting that was held by the
3 Center for Drugs, one presenter applauded FDA's new policy
4 of direct-to-consumer advertising, and I quote, "It is
5 serving the public interest, empowering patients with
6 information, prompting them to seek medical help, and
7 promoting treatment of underserved populations."

8 And at the same meeting, on the other hand, the
9 consumer advocates equally vigorously complained about what
10 one of them called a blitz of drug advertising without any
11 balancing flow of unbiased information and charge that
12 because their brevity, direct-to-consumer advertisements,
13 cannot provide consumers with adequate risk-benefit
14 information, and in that sense, they are inherently
15 misleading.

16 There was some division of opinion even about the
17 desirability of user fees, which were strongly rejected by
18 several speakers, including one industry spokesman at a
19 meeting who said that his organization is categorically
20 opposed to paying for the privilege of Government-imposed
21 consumer protection programs and added, "I guess we cannot
22 say it any stronger or any louder."

23 Yet, at the Foods meeting, a representative of
24 eight firms that produce most of this country's food
25 additives just as strongly supported legislation to

1 authorize user fees for his industry.

2 This variety of views has been no surprise to us
3 because, as you know, we try in every conceivable way to
4 keep in very close touch with our constituencies, and at
5 least, we were reassured by the fact that the presentations
6 reinforced the impressions that we already had from our
7 regular contacts with our constituencies.

8 The meetings have provided at least some of the
9 guidance that we need to develop the plan that is required
10 in Section 406(b) of the Modernization Act, and the reason
11 for this is because for all of their differences, a great
12 majority of the stakeholders from whom we have heard so far
13 have shown really strong impressive support for several
14 themes and approaches that clearly they regard as in the
15 best interest of the public health as well as in their own
16 best interest. Therefore, they want FDA to include these
17 things in the planning.

18 First of all--and this is really a very important
19 and heartening signal for all of us in the agency--I have to
20 emphasize one theme that was almost never raised at any of
21 the meetings, and that is a call for lowering any of our
22 product standards.

23 To our very great satisfaction, the high public
24 health goals that we have set over the years are
25 unchallenged, and they are recognized as indispensable for

1 the continued success and vitality of our society.

2 Of all the themes that were repeatedly raised, I
3 have already mentioned the almost unanimous call for
4 increased resources for the agency that constituents also
5 agree that the streamlining and the modernization and the
6 other important changes that the agency started several
7 years ago should be further advanced and further amplified.

8 There is a general desire that there should be a
9 still greater effort, as Linda alluded to earlier, to make
10 FDA's processes more transparent, more consistent, more
11 predictable.

12 Another prevalent theme, increased cooperation,
13 increased communication. There is an overwhelming support,
14 wall to wall, from all of our stakeholders on that front.
15 So, even though we think we have been communicating a lot,
16 apparently we just can't do enough to satisfy all of our
17 constituencies.

18 People want a closer dialogue. They want greater
19 information exchange, and they want FDA to involve itself in
20 more collaborative and cooperative efforts, both with the
21 consumer community as well as with the regulated industry,
22 with academia, as well as with health practitioners, and
23 also with the scientific community. They want us to be even
24 more closely involved with State and local public health
25 authorities in this country, but they also want us to

1 increase our interactions with international organizations
2 and with our regulatory counterparts in foreign countries.

3 There is strong agreement among all of our
4 stakeholders that public health protection is a global
5 responsibility, and that the job can only be done if we
6 cooperate across the board with everyone that we can.

7 Finally, we were time and time again advised to
8 explore more fully the use of third parties as one way of
9 getting the job done without increasing FDA staff.

10 So these, then, are some of the main impressions
11 after hearing from a significant portion, but really only a
12 portion of our constituents. Perhaps I should add that I
13 presented this just as a background for our discussion, and
14 without any intent to influence the presentations that we
15 are going to hear this afternoon.

16 But having said that, let me just add one
17 disclaimer. One of the things that I would have to note
18 that virtually all of the presenters failed to do is address
19 one of the most difficult problems that the planners are
20 going to face; that is, which programs that we currently
21 carry out should be de-emphasized or even scrapped
22 altogether.

23 Regardless how hard we have pressed on this issue,
24 no stakeholder has been ready, as one of them put it, to
25 come here and say quit doing this and quit doing that.

1 Obviously, we can take this as a compliment to the
2 way we have been targeting our limited resources, but it is
3 also a glaring shortcoming of the consultation process. I
4 would, therefore, like to end my report with a little bit of
5 advocacy and encourage, if at all possible, the panelists
6 this afternoon who as health professionals, probably more
7 than any other group, appreciate the fact that sometimes you
8 have to take your medicine even when it is
9 unpleasant-tasting because it has benefits, if you can give
10 us your best views not only on what we should be doing, but
11 perhaps what we can stop doing, in order for us to carry
12 out all of our responsibilities under the Federal Food, Drug
13 and Cosmetic Act.

14 So, with that, I am now going to ask Dr. Stuart
15 Nightingale, our associate commissioner for Health Affairs,
16 to introduce and bring forward our panelists so that we can
17 start our discussion.

18 Thank you very much.

19 **Stakeholders/Centers issues for Health Professionals**

20 DR. NIGHTINGALE: Would the panelists please come
21 up?

22 DR. FRIEDMAN: Stuart, while they are coming
23 forward, let me just add one thing, if I may.

24 Unfortunately, I have got something that is going
25 to call me away probably in another 30 minutes or so. I

1 very much apologize for that.

2 I look forward to hearing what people have to say
3 for the brief time I will be here, but please do not
4 misinterpret my having to be somewhere else as anything but
5 a horribly clogged schedule.

6 DR. NIGHTINGALE: Thank you, Dr. Friedman.

7 In fact, we have invited all our first presenters
8 to remain as part of the FDA reactor panel.

9 I am Dr. Stuart Nightingale, the associate
10 commissioner for Health Affairs at FDA. I would like to add
11 my welcome to those of the others and say how pleased I am
12 to have such excellent participation today, both the
13 speakers and the audience.

14 I do want to thank the acting commissioner and
15 Sharon Smith Holston and Linda Suydam for so eloquently
16 setting the stage for our panels.

17 I would like to say a word or two about how we
18 organized the rest of today's session. First, we have
19 assembled a panel of broad-based general health professional
20 organizations to make 5-minute presentations.

21 Following each presentation, a panel of senior FDA
22 center officials and the others I mentioned, will ask
23 questions to clarify or probe specific issues that have been
24 raised by the organizations.

25 Then I would like to, if possible, reserve some of

1 the more interactive-type questions for discussion that can
2 take place at the end of all the presentations, should we
3 have time for that.

4 After a break, we will then hear from the
5 stakeholders who are not part of this first panel. At this
6 time, we have five organizations that have requested 5
7 minutes each. I will ask them to come up as a group and sit
8 where the first health professional organization panel was.

9 The FDA center officials will remain and have the
10 same opportunity to react to their presentations. However,
11 should more individuals wish to make presentations from the
12 audience, we might need to modify that procedure and have
13 only individual presentations with questions immediately
14 following each of their statements.

15 To help us in our planning for the post-break
16 session, I would appreciate that any group that might wish
17 to speak in addition to those that are already listed on the
18 agenda, please go to the registration desk and give them
19 your name and organization during this sessions or, at the
20 latest, at the break.

21 Finally, we do not want to discourage anyone from
22 speaking later in the session after the break, and if there
23 is time, we will permit others to speak, but perhaps for
24 less time. We will have to sort of see how things progress
25 to make that decision.

1 Now I would like to turn to our panels. Given the
2 shortness of time, I will not introduce the health
3 professional organization representatives at this time, but
4 will call on them to speak, giving their name and
5 organization that they represent.

6 For sake of clarity, I would then ask the speakers
7 to identify themselves, their titles, and to say a few words
8 about the organizations that they represent, including the
9 membership.

10 At this time, I will introduce the FDA reactor
11 panel, and they are, starting on my left: Dr. Michael
12 Blackwell, who is the deputy director of the Center for
13 Veterinary Medicine; Mr. Robert Lake, director of the Office
14 of Policy, Planning and Strategic Initiatives in CFSAN; Ms.
15 Deborah Henderson, director, Executive Operations Staff in
16 CDER; Dr. David Feigal, deputy director, Medicine, for CDER;
17 and Dr. Susan Alpert, who is replacing Dr. Bruce Burlington.
18 She is the director of the Office of Device Evaluation at
19 CDRH.

20 Before calling on our first speaker, I would like
21 to ask the organization to submit for the record copies of
22 their statements, if available. This will assist us in the
23 transcription and in preparing our summary.

24 Also, when making presentations, if you are
25 addressing a specific question that is identified in the

1 Federal Register Notice for this meeting or the especially
2 prepared questions that we have for health professionals
3 that is in your packet, you might want to identify those.
4 This can help us in the preparation of our summaries.

5 I would like to now call on Dr. Bruce Rothwell,
6 representing the American Dental Association.

7 DR. ROTHWELL: Good afternoon. As you just
8 learned, I am Dr. Bruce Rothwell. I am from the other
9 Washington. My real job is at the University of Washington
10 in Seattle.

11 I am here today representing the American Dental
12 Association or the ADA, as we refer to it. I am also
13 accompanied by Dr. Cliff Wall, who is the director of
14 Product Evaluation and a senior scientists at the ADA, most
15 involved with product evaluations and the seal program.

16 The ADA represents 143,000 members which are
17 approximately 75 percent of all licensed dentists in the
18 United States.

19 As dental practitioners, researchers, and
20 teachers, and as public health advocates, the ADA members
21 have a keen interest in the continued viability and good
22 health of the Food and Drug Administration.

23 We also believe that dentistry has a role to play
24 and a distinct contribution to make in the modernization of
25 the FDA.

1 I am here today representing the dental profession
2 because I am currently the chair of the ADA's Council on
3 Scientific Affairs.

4 Since 1928, the ADA, through this council and its
5 predecessors, has taken the lead in developing voluntary
6 consensus standards for dental materials, instruments, and
7 equipment.

8 Since 1930, the ADA has operated its unique and
9 highly regarded seal of acceptance program. This voluntary
10 program rigorously evaluates dental drugs, materials,
11 instruments and equipment in terms of their safety and
12 efficacy, and the truth of their advertising claims.

13 The American Dental Association has one clear
14 message to deliver to the Food and Drug Administration
15 today. It responds to the spirit and the letter of the new
16 law, and it also speaks to the fact that this law places new
17 burdens on an agency that is already overburdened.

18 This is our message. We want to work with the
19 FDA. We want to assist the agency in every way possible to
20 get safe and effective dental products into the marketplace
21 and out to practitioners and consumers in a timely way.

22 We feel that we are in a position to do that. We
23 have the experience through the Council on Scientific
24 Affairs. The ADA has more than 70 years of experience in
25 developing product guidelines, standards, and

1 specifications, and in evaluating dental products against
2 those criteria.

3 We also have the expertise in addition to the
4 17-member counsel. The ADA has more than 100 expert
5 consultants who volunteer their time to develop consensus
6 guidelines for clinical and laboratory testing of dental
7 products.

8 We have a staff of talented scientists working in
9 our Chicago headquarters, and we also have laboratory
10 testing facilities there.

11 Today, approximately 1,300 dental products bearing
12 the well-known ADA seal of acceptance have been evaluated by
13 our scientists and validated as appropriate in ADA
14 laboratories.

15 In the remainder of my brief statement today, I
16 will lay out for you how I think we can help the FDA in that
17 regard. I will also try to describe the tools and resources
18 and expertise that the ADA and its Council on Scientific
19 Affairs can bring to bear.

20 I will close by requesting a follow-up meeting to
21 further examine the possibility of a working partnership
22 with the FDA.

23 We believe that the FDA could benefit by taking a
24 close look at our seal of acceptance program, which
25 evaluates dental products based upon safety and efficacy,

1 the main evaluation criteria used as well by the FDA.

2 The agency could, for example, expedite the
3 approvals of any dental products that already have earned
4 the ADA seal.

5 Because of its thoroughness and longevity, the
6 seal of acceptance program enjoys widespread recognition and
7 acceptance and trust among consumers. It is regarded as the
8 gold standard among private sector product evaluation
9 programs. For example, Time magazine called it the model
10 commercial arrangement for a health group.

11 The ADA seal is also trusted by dentists. In a
12 1995 survey, a substantial majority of dentists in the
13 United States reported that the ADA seal of acceptance plays
14 a part in their selection purchase and use of dental
15 products.

16 This acceptance program is an outgrowth of the ADA
17 mission to encourage the improvement of the health of the
18 public and promote the art and science of dentistry. I
19 think dentistry has an enviable record in promoting the
20 health of the public and promoting public health in general
21 in preventive programs, and this is part of that program as
22 well.

23 As I mentioned earlier, the ADA seal program is
24 voluntary. Commercial dental products are evaluated for the
25 ADA seal of acceptance at the request of manufacturers or

1 distributors.

2 Applicants must submit extensive and detailed
3 information about the nature, function, operation, and
4 composition of their products, including details and
5 conditions of manufacturer. All candidate products must be
6 manufactured in compliance with FDA good manufacturing
7 practices.

8 Applicants are required to provide objective data
9 from laboratory and clinical studies. As appropriate, we
10 also evaluate labels, patient package and inserts,
11 advertising copy, and other promotional and educational
12 materials.

13 Only those claims that can be supported by sound
14 scientific studies and appropriate laboratory or clinical
15 data are permitted.

16 As I said, at present, 1,338 products carry the
17 ADA seal of acceptance. This includes 781 professional and
18 prescription products and 557 over-the-counter products.

19 Until 1995, when costs became prohibitive, all
20 products were tested at ADA expense. Today, the association
21 charges modest application and maintenance fees which
22 recover about 30 percent of the cost of operating the
23 program. There is no association profit in the seal
24 program.

25 To support the seal of acceptance program, the ADA

1 Council on Scientific Affairs develop guidelines that
2 specify the kinds of scientific studies that must be
3 conducted to appropriately evaluate a given dental product
4 for safety and efficacy. This is especially important in
5 the case of certain product categories, notably drug
6 products, which are not amenable to existing consensus
7 standards or specifications.

8 Often, ADA guidelines are ahead of the FDA and,
9 therefore, can be extremely useful to the agency as it
10 evaluates dental products for safety and efficacy.

11 The ADA guidelines are typically developed through
12 workshops and consensus conferences that draw on the
13 state-of-the-art guidance from experts in the field.

14 In April, the ADA submitted 28 sets of guidelines
15 to the FDA for consideration and adoption, and I am
16 including these as an attachment to the material that we are
17 submitting today and ask that they be made part of the
18 record.

19 The ADA is also heavily involved in developing
20 both national and international standards for dental
21 products.

22 At the same time we submitted the guidelines, we
23 also submitted 38 dental specifications recognized by the
24 American National Standards Institute, ANSI, as American
25 national standards.

1 I would like to say that our efforts in this
2 regard have been successful, but they were not. About 2
3 weeks ago, ADA staff queried the FDA Center for Devices and
4 Radiological Health to find out if any of the voluntary
5 standards submitted by the ADA had received agency
6 recognition. The answer was no.

7 The ADA was told that CDRH reviewers were unable
8 to review any of the ADA guidelines or standards during this
9 cycle because of a lack of reviewers with dental expertise.

10 We expect that the ADA will try again. Its
11 understanding is that another listing may be published in
12 January.

13 This is a conclusion of my remarks, and, again, I
14 would like to thank the FDA for inviting us to present the
15 position of organized dentistry with regard to the FDA and
16 the implementation of the Food and Drug Administration
17 Modernization Act of 1997.

18 I hope our thoughts will be useful to the agency
19 as it develops the implementation plan that Congress expects
20 to see in November.

21 The main thought I want to leave you with today is
22 that the ADA is very much interested in exploring the idea
23 of a working partnership with the FDA, and to that end, we
24 are requesting a follow-up meeting in the near future.

25 I also want to invite agency panelists to take a

1 look at some of the additional information describing the
2 evaluation programs at the ADA. I have a packet regarding
3 the seal program and some additional information.

4 Either Dr. Wall or myself would be happy to answer
5 questions during the appropriate time.

6 Thank you.

7 DR. NIGHTINGALE: Thank you, Dr. Rothwell.

8 Are there any questions from the FDA reactor panel
9 or comments you want to make right now?

10 Yes.

11 DR. ALPERT: I would just say that it is, in fact,
12 true that there will be other opportunities for the dental
13 standards to be addressed. This is an ongoing process, and
14 we did receive probably 400 nominated standards. And we are
15 working our way through all of them.

16 DR. NIGHTINGALE: Dr. Blackwell?

17 DR. BLACKWELL: Dr. Rothwell, I just wanted to
18 better understand the expedited review that you suggest the
19 agency considers on these products that have received the
20 seal.

21 Is it your concept that there would be some
22 limited review of the same information, or you would replace
23 certain aspects of our review of those products? Could you
24 just expand on that a little bit?

25 DR. ROTHWELL: Well, it seems like the mechanism

1 is something that we could work out, but I think it would be
2 anticipated that possibly products which had already
3 received the seal and gone through that testing program
4 might be on a fast track through the FDA or might have some
5 expedited evaluation process through the FDA.

6 Our understanding from the manufacturers is that
7 they really want to reduce or eliminate the duplication in
8 evaluation, and if we are going to be evaluating a product,
9 possibly you could do a faster-track, expedited kind of
10 review.

11 DR. NIGHTINGALE: Any other questions or comments?

12 [No response.]

13 DR. NIGHTINGALE: If not, thank you very much, Dr.
14 Rothwell, and let's go on to Dr. Joseph Cranston, who is
15 representing the American Medical Association.

16 DR. CRANSTON: Thank you.

17 My name is Joe Cranston. I am the director of the
18 Department of Drug Policy at the American Medical
19 Association which represents approximately 275,000
20 physicians and physicians in training.

21 We thank you for the opportunity to speak today.
22 While the stakeholders meeting is being held to satisfy
23 Section 406 of FDAMA, I am not going to specifically address
24 the six questions in the Federal Register Notice. Rather,
25 I will present more global views of the AMA based on our

1 policies and positions.

2 The AMA supported the version of FDAMA that was
3 ultimately passed into law because we believe FDA efficiency
4 and accountability can be improved without sacrificing
5 safety and efficacy.

6 I want to emphasize that the AMA has been one of
7 FDA's most ardent supporters in ensuring that the standards
8 for efficacy and safety not be compromised in approving new
9 medical products.

10 Throughout the FDAMA, the AMA has also emphasized
11 the FDA can only accomplish its mission if it is adequately
12 funded to do so. The agency must prioritize its activities
13 and do what it can do within the budget that it has been
14 given.

15 The AMA believes the Prescription Drug User Fee
16 Act of 1992 was highly successful because it provided the
17 FDA with extra monies to specifically devote to improving
18 its performance and reviewing new drug applications. The
19 AMA supported PDFUA, too, in anticipation that further
20 improvement in this area will occur.

21 In Section 406(a) of FDAMA, the Congress gave the
22 FDA a mission statement. The AMA supports this mission. In
23 particular, the FDA must find the proper balance between
24 protecting the public health that is assuring our foods are
25 safe and our medicines, and medical devices are both safe

1 and effective, and promoting the public health, that is,
2 ensuring that important and innovative new products reach
3 the marketplace in a timely manner.

4 As already noted, we believe that PDFUA
5 reauthorization will help accomplish this second goal for
6 prescription drugs.

7 In the mission statement, the Congress
8 appropriately recognized the importance of international
9 harmonization. The AMA has been on the record for a number
10 of years as promoting international harmonization of
11 technical requirements for medical product approval as a
12 means to decrease redundant scientific experimentation and
13 to conserve resources. The FDA has encouraged to move full
14 speed ahead in this area.

15 In prioritizing medical product approval--and my
16 experience is primarily in the drug area--the FDA must take
17 into account disease severity and availability of effective
18 and safe alternatives.

19 While medical products for patients with
20 life-threatening diseases for which no market alternative
21 has existed to serve FDA's priority, the AMA commends the
22 agency for its accelerated or fast-track approval and
23 expanded access programs, now codified into law by FDAMA.

24 The AMA emphasizes, however, that when accelerated
25 approval is based on surrogate endpoints that necessary

1 post-marketing studies must be done to confirm the benefit
2 risk using clinical endpoints.

3 Furthermore, expanded access should not interfere
4 with the conduct of randomized control trials to prove
5 efficacy.

6 On the safety side, the AMA is very committed to
7 patient safety, having recently established the National
8 Patient Safety Foundation, and Dr. Bruce Burlington of the
9 FDA is on the NPSF's board.

10 The AMA also has been an active partner in the
11 FDA's MedWatch program, having cosponsored a MedWatch
12 conference, among other activities. The AMA believes
13 MedWatch has been successful in identifying rare, but
14 serious adverse events associated with medical products
15 after marketing.

16 Furthermore, we concur with the agency that it was
17 because of MedWatch that recent problems with Posicore and
18 Direct were identified.

19 Finally, the AMA also believes the FDA has an
20 important role to play in ensuring that error-prone aspects
21 of medical products are minimized, such as doing error
22 prevention analysis during labeling and packaging design
23 regulatory activities.

24 Before closing, I would like to briefly hit upon
25 some very specific issues where the AMA has particular

1 interest. First, the AMA applauds the FDA's efforts to
2 regulate tobacco, and subject to the courts, supports a
3 continuation of your activities in keeping tobacco products
4 out of the hands of minors.

5 The AMA was supportive of Section 111 of FDAMA,
6 the pediatric study section, and the FDA's recent proposed
7 rule in this area. We strongly urge the agency and the
8 regulated industry to move forward quickly to include
9 children in research studies and to gain FDA-approved
10 labeling for pediatrics.

11 The AMA has been supportive of changes in
12 professional product labeling, that is, the package insert,
13 to make it more user friendly for physicians, and we ask the
14 FDA to issue the proposed rule on this topic.

15 Similarly, we encourage the FDA to complete its
16 regulatory activities on OTC labeling to make it more useful
17 to consumers.

18 Areas of AMA concern, including FDA interference
19 with medical practice, direct-to-consumer advertising of
20 prescription drugs, and off-label information dissemination.

21 The AMA has always maintained, and I believe the
22 FDA agrees, that individual States regulate medical
23 practice. However, the FDA has a broad mandate to protect
24 the public health, and sometimes the FDA makes regulations
25 that ultimately dictate how physicians can practice.

1 In some cases, this is probably necessary to keep
2 a particular product on the market, such as Thalidomide or
3 Accutane.

4 On the other hand, the AMA believes that programs
5 such as MedGuide are unnecessary intrusions into
6 professional practice, and we believe the FDA should make
7 every effort not to interfere with the physician-patient
8 relationship.

9 The AMA does not totally oppose direct-to-consumer
10 advertising of prescription drugs, but we are concerned that
11 the recent decision to make it easier to advertise in our
12 broadcast media will result in a plethora of promotion with
13 little educational value. We are especially concerned that
14 physicians will be pressured by patients to switch to
15 "advertised drugs," and the AMA has asked the FDA to survey
16 physicians on this issue.

17 The AMA supports FDA regulation of the promotional
18 activities of prescription drug manufacturers. However, the
19 AMA also supported Section 401 of FDAMA that would allow
20 independently derived scientific articles about off-label
21 uses from peer-reviewed journals to be disseminated by
22 pharmaceutical manufacturers.

23 We were dismayed with the FDA's recent proposed
24 rule in this area because it plays too many restrictions on
25 what types of articles could be disseminated. This clearly

1 was not consistent with the intent of FDAMA.

2 I am going to stop at this point, and again, the
3 AMA appreciates the opportunity to comment.

4 Thank you.

5 DR. NIGHTINGALE: Joe, thank you.

6 Any questions or comments from the FDA panel?

7 Debbie?

8 MS. HENDERSON: I have one.

9 Dr. Cranston, several times you emphasized the
10 need for us to balance safety versus the need to get things
11 out there, and we, of course, agree with you that this is a
12 horrible balance for us to always be looking at.

13 The current way that we look at safety of
14 products, at least in the Center for Drugs, is through our
15 error system which really is designed to detect rare,
16 unusual events.

17 Does the AMA believe that we need to put more
18 effort into sort of looking at the overall safety profile of
19 drugs which, of course, would be a different effort than we
20 are currently doing?

21 DR. CRANSTON: Frankly, we have not really
22 specifically addressed it, but in anticipation of the
23 question, I think that you ought to look at this very
24 carefully before you move ahead.

25 I know you have gotten a lot of criticism recently

1 because of the JAMA article and because of the recent
2 withdrawals. However, I think that to go forward with some
3 type of mandatory reporting program, it could potentially
4 backfire, and it could actually diminish reporting.

5 I would encourage you to talk to some of the
6 experts in the field, people like Leep at Harvard, Dave
7 Klasnet at LDS Hospital in Utah, and look at some of the
8 computerized programs that these groups have developed,
9 particularly LDS. I believe they can very easily pull out
10 the adverse events and separate them into errors, separate
11 them into actual ADRs.

12 I think you should be very careful as you move
13 forward.

14 MS. HENDERSON: Thank you.

15 DR. NIGHTINGALE: Yes. Bob?

16 MR. LAKE: As the person representing the food
17 side of the house, I was interested in your comments on
18 promotion of pharmaceuticals. I wondered if you had any
19 comments about the labeling or advertising of food products
20 as well.

21 DR. CRANSTON: No, not specifically.

22 I think our concerns have really fallen more into
23 the area of dietary supplements. We just sent a letter off
24 to you about a week or so ago. I think there is concern
25 that your ability to regulate those types of claims raise

1 some serious concerns.

2 DR. NIGHTINGALE: Thank you.

3 Yes, Susan.

4 DR. ALPERT: Yes.

5 Dr. Cranston, you mentioned several of the
6 labeling initiatives as being a very positive step forward.
7 I wondered if the AMA--and I will ask if others on the panel
8 have any recommendations about other ways in which we can
9 expand our communication about products that do reach the
10 marketplace, particularly new products. That is an area of
11 outreach that we are quite interested in.

12 DR. CRANSTON: Yes. This is actually my own
13 suggestion, and it is one I have made to Dr. Nightingale
14 personally.

15 I guess I would like to see health professional
16 organizations, including my own--and I do not have control
17 over this area--but to have a hot button on our home page
18 which is an FDA hot button, and the really critical stuff
19 that you have to send out to health professionals and to the
20 organizations could be somehow lumped across your centers.
21 Physicians or pharmacists or nurses could access that on a
22 daily basis. It would probably get increased traffic for
23 our web sites as well as get this information out better.

24 I am specifically thinking of the types of things
25 that we get called upon or get faxed on almost on a weekly

1 basis, you know, obviously withdrawals, when there is a
2 shortage of something like the immunoglobulins or when you
3 have a new approval or the advisory committee makes a major
4 decision such as the tamoxifen decision of a week or so ago.
5 I really think something like that would be very useful.

6 I will be honest. I have not brought it forward
7 in greater depth with my own web people, but I think it is
8 something to really think about.

9 DR. NIGHTINGALE: Any other comments or questions?

10 [No response.]

11 DR. NIGHTINGALE: Dr. Cranston, thank you very
12 much. Perhaps maybe we can explore some of that later in
13 the discussion.

14 Now I would like to turn to Eileen McGrath
15 representing the American Medical Women's Association.

16 MS. McGRATH: Good afternoon. My name is Eileen
17 McGrath, and I am the executive director of the American
18 Medical Women's Association, and I appreciate very much the
19 opportunity to comment today.

20 The American Medical Women's Association is an
21 82-year-old organization of 10,000 women physicians whose
22 mission is to promote women's health, and I will restrict my
23 comments today to that since that is an area we feel
24 deserves special focus and is often neglected.

25 The FDA recognized 5 years ago that there was a

1 need for specialized focus on women's health to redress past
2 discrepancies, and it recognized it in three ways, one by
3 promoting special activities within the FDA, another by
4 issuing guidelines for gender analysis, and a third by
5 reviewing the adequacy of the inclusion of women in clinical
6 trials.

7 At this 5-year mark, there is a need to review the
8 agency's efforts to integrate women's health focus into the
9 fabric of the agency's administration in order to determine
10 the remaining need for this special focus.

11 In this second stage of the focus on women's
12 health, there needs to be more science orientation. It has
13 been 5 years since the publication of the guidelines on
14 gender analysis and requirements of the guidelines for
15 including women in clinical trials, and there needs to be a
16 summary of the successes and failures to date of this effort
17 in order to determine if the guidelines need to be
18 formalized as regulations and to determine if we need to go
19 further.

20 While there certainly has been a level of
21 responsiveness on the part of industry, we are not where we
22 need to be. It is time to take stock of where the agency is
23 with regard to women's health at both the review level and
24 the policy level. The guidelines were a nudge, but
25 regulations are needed to ensure continued progress.

1 It is apparent that women's health is of
2 significant economic interest to industry. The agency in
3 its role of protecting public health needs to evaluate the
4 quality and the scientific basis of the quality of clinical
5 activities and data to ensure that the guidelines are not
6 near window-dressing.

7 The agency must ask the questions, are both the
8 internal FDA policies and industry response consistent with
9 the goals of women's health.

10 In view of the Modernization Act which requires
11 the FDA to be more facilitative of industry, the FDA must be
12 very specific about what industry needs to do to get a
13 product approved; in other words, the least-restrictive
14 route to market.

15 A critical question which must be asked is, is
16 this consistent with good science and the goals of health
17 overall, and particularly the goals of women's health which
18 has historically been neglected.

19 Is there a vulnerability in streamlining and
20 accelerating? Does it advance clinical trial management
21 design and analysis?

22 Another area of concern is gender issues with
23 regard to the regulation of devices and biologics as well as
24 drugs.

25 With the current budget reductions, it may be that

1 these issues could be more effectively addressed with a
2 collaborative effort from elements outside the review
3 division, which could add greater science base to the review
4 division. This might be a role for the Office of Women's
5 Health within FDA.

6 This collaboration could potentially provide
7 greater attention to the issue of what progress is being
8 made across the board in women's health with a focus which
9 includes devices, as well as drugs.

10 After 5 years, it is time to take stock of what
11 has happened under the guidelines in the Office of Women's
12 Health and to look at the issues of expanding the inclusion
13 of women in clinical trials.

14 There are additional areas in which AMWA urges the
15 FDA to be more proactive in women's health, and that is in
16 reproductive health and tobacco control.

17 AMWA applauds the FDA for its recent approval of
18 an emergency contraceptive product. We urge the agency to
19 encourage the development of additional needed products in
20 reproductive health.

21 AMWA has long been active in advocacy efforts to
22 oppose the targeted marketing of tobacco products to women
23 and girls. We realize that any proposed oversight functions
24 of Government to the tobacco industry are limited to use by
25 minors, but we urge the agency to consider gender

1 differences in any regulatory efforts. There are
2 differences in tobacco use by girls and boys, and to be
3 effective in reducing use by minors, those differences need
4 to be taken into consideration.

5 We urge the agency to be collaborative with other
6 public health agencies in this effort. No agency has the
7 resources to target this great giant alone. WE all have to
8 work together.

9 We thank you again for the opportunity.

10 DR. NIGHTINGALE: Thank you.

11 Are there any questions or comments from the
12 panel?

13 Yes.

14 DR. BLACKWELL: You may have answered this and I
15 just missed it, but what is the proposed or suggested role
16 for the Office of Women's Health in collaborating with the
17 centers?

18 MS. McGRATH: In reviewing the activities of the
19 Office of Women's Health over the past 5 years, we think
20 that it has taken on very important initiatives, but we
21 think that there needs to be more of a science base to
22 women's health issues, particularly as we streamline and
23 accelerate.

24 We think that with the limitations and resources
25 that we were shown earlier on the slide presentation that

1 one way to utilize the Office of Women's Health might be to
2 get the Office of Women's Health to look at the scientific
3 basis of the management of clinical trials and design of
4 clinical trials particularly.

5 DR. NIGHTINGALE: Thank you.

6 Any other comments?

7 Bob?

8 MR. LAKE: The Food Center at FDA also has
9 responsibility for cosmetics, and I wondered if you had any
10 comments about gender issues relating either to foods or
11 cosmetics.

12 MS. McGRATH: We have not included that in our
13 focus, but it is an area that we should look at. So I thank
14 you for the question.

15 DR. NIGHTINGALE: Any other comments, questions,
16 or thoughts?

17 [No response.]

18 DR. NIGHTINGALE: Well, thank you, Ms. McGrath.

19 Let's move on, then, to Ms. Cheryl Peterson who is
20 replacing Dr. Beverly Malone, representing the American
21 Nurses Association.

22 MS. PETERSON: Good afternoon. My name is Cheryl
23 Peterson, and I am the senior policy fellow of the
24 Department of Health and Economic Policy at the American
25 Nurses Association.

1 ANA represents 200,000 registered nurses here in
2 the U.S. In addition, we are the U.S. member to the
3 International Council of Nurses. So we are very pleased to
4 see this targeting of international issues.

5 First, we would like to applaud the FDA for
6 holding this kind of stakeholder meeting. I think this is
7 the first step in trying to improve your communication, is
8 really reaching out to associations in a mechanism beyond
9 just asking for comment in the Federal Register.

10 Oftentimes, it is a very sterile procedure that
11 does not allow for some real give-and-take on the
12 discussion. So we believe that this is absolutely critical
13 to your really trying to expand and improve your ability to
14 respond to your increasing workload and the increasing
15 issues that are facing health care providers, which is our
16 interest, in particular.

17 We would urge you that whatever process that you
18 look at and that you move forward that it really be open and
19 transparent. It needs to be clearly explained. It needs to
20 be articulated in a way that is easily understood and
21 accessible to health care providers.

22 And I say the language health care providers so
23 that you understand that there is more than just our groups
24 that are represented here, and I would urge you to use that
25 language as opposed to focussing on a particular type of

1 provider and that you, where possible, use as broad a
2 language.

3 The one thing that we have noted that we feel has
4 been very successful in working with the FDA is recently, we
5 collaborated with the FDA on a latex allergy satellite
6 conference, and in trying to reach out to the health care
7 provider community, that was an excellent way of trying to
8 educate them about the issue of latex allergy, which is of
9 big concern for nursing. And we would add to that the issue
10 of needle sticks.

11 What we would also encourage you to do is to
12 collaborate and work more closely with the other agencies.
13 The Occupational Safety and Health Administration, the
14 National Institutes of Occupational Safety and Health have
15 both done a fair amount of work around latex allergy and
16 needle stick also, and they are looking towards doing some
17 more work in particular around needle sticks. These are
18 significant occupational hazards for health care providers,
19 as well as for registered nurses, and it must be addressed
20 through product development.

21 So you really need to be talking to these other
22 agencies who have some scientific background and who, with
23 regard to OSHA, have the regulatory ability to go in and
24 address some of the issues.

25 In addition, it just decreases the duplication of

1 effort, both on your part as well as on ours. If we can
2 talk to more than one of you at one time, that is very
3 helpful, and it is the same for you as well, I think.

4 With regard to the international issues, we are
5 very concerned about the conflict between the need to open
6 markets, which has a financial benefit, both for the United
7 States as well as for our international partners, which the
8 United States Trade Representative office is, of course,
9 very interested in, but we also believe that there is a more
10 important interest here, and that is ensuring the safety of
11 the public.

12 And that where you look at harmonization of
13 standards and product development, that you make sure that
14 you do not lower the standard, but that, in fact, you raise
15 the standard.

16 We are looking at harmonization within regulation
17 of nursing practice, and we have this same issue, that you
18 cannot lower the standard, and you must look to raise it.

19 Concurrently to that, we need to make sure that we
20 are not dumping products that we have decided here in the
21 U.S. are inappropriate and that we ship them off to other
22 countries in an effort to remove our stockpile, that they
23 are inappropriate for the U.S. and they are inappropriate
24 for other areas as well.

25 Finally, we would just like to urge you to

1 continue your efforts around tobacco. ANA is strongly
2 supportive of that, and we will continue to advocate for
3 that initiative.

4 Finally, I would join my colleague from the
5 American Medical Women's Association on making sure that you
6 continue your work around establishing better contraceptive
7 drugs and devices. That is an area that we are very
8 concerned about and urge you to continue your efforts there.

9 Thank you.

10 DR. NIGHTINGALE: Thank you, Ms. Peterson.

11 Are there any questions or comments from the FDA
12 group?

13 Debbie?

14 MS. HENDERSON: I have one.

15 We really recognize that we do not do as well as
16 we could in being open and transparent and communicating,
17 and one of the groups that has recently come to our
18 attention is the nursing community.

19 Do you have any suggestions for how we may better
20 communicate with the nursing community?

21 MS. PETERSON: First of all, in talking to groups
22 like the ANA, we are part of a collaborative group or forum
23 that has 73 nursing associations that are a part of it, and
24 that is your specialty organizations and other large nursing
25 associations, and again, I would reiterate an avenue to

1 reach the international nursing community.

2 Unfortunately, while we are an age of technology,
3 we are also still an age of paper, and there are a lot of
4 nurses out there that may not necessarily have immediate
5 access to computers and web sites and the technology. So
6 there still is the need to continue to develop short,
7 one-paged pieces that we are glad to copy and send out and
8 distribute as broadly as we can, but there still is that
9 need for that kind of short intense kind of communication.

10 DR. NIGHTINGALE: Any other comments or questions?

11 [No response.]

12 DR. NIGHTINGALE: No? Well, in that case, thank
13 you, Ms. Peterson.

14 Let's turn now to Dr. Lucinda Maine, who is
15 representing the American Pharmaceutical Association.

16 DR. MAINE: It is a pleasure to be here this
17 afternoon.

18 A-P-little "h"-A, to distinguish my organization
19 from the organization that follows, represents the
20 approximately 200,000 pharmacists, pharmacy students, and
21 pharmaceutical scientists in the United States. Our
22 membership of 52,000 generally tracks the demographic
23 profile of the pharmacists, scientists, and students.

24 I will address a couple of the key questions in
25 your September 2nd query, including several that are high

1 priorities for our organization.

2 My take-away message will mirror that, that Sharon
3 Holston mentioned before. Cooperation, prioritization, and
4 partnership are going to be needed to address the far-reaching
5 goals and the objectives of the agency in a time of dramatic
6 scientific advancement that truly offers great promise for
7 the care of the public that you are charged to protect.

8 My first comments relate to the availability and
9 clarity of information about the review process itself.

10 Speaking only for the education of pharmacists,
11 the opportunity exists through APhA, as well as, I am sure,
12 other organizations in pharmacy, like the American
13 Association of Colleges of Pharmacy, to provide up-to-date
14 material on important aspects of and changes in the drug
15 review and approval process for both pharmacy students and
16 current professionals.

17 The partnership between APhA and FDA to deliver
18 this information through the Internet is one possibility.
19 Publications and live podium presentations are others,
20 although the latter is obviously more costly and perhaps
21 limited in scope.

22 I believe I am accurate in saying that virtually
23 all schools and colleges of pharmacy include in their
24 curricula information about the phases of drug research and
25 the application review processes. A faculty, I believe,

1 would welcome fresh and accurate materials to include in
2 these courses.

3 Such communication might also stimulate additional
4 interest among faculty and contemporary clinicians in
5 addressing your fourth objective related to the manpower for
6 panels and review.

7 FDA obviously depends on large numbers of health
8 care providers serving as clinical scientists as members of
9 your advisory panels. The system seems to serve the public
10 and the agency well. APhA would welcome the opportunity to
11 cooperate with FDA in the process of stimulating such
12 interest and identifying new candidates for panels,
13 scientists, and residents, and other participants in this
14 key aspect of your work.

15 As for improving the work of institutional review
16 boards, which was one of your specific questions, a small
17 and very informal poll of pharmacists involved in such work
18 agree that communication and education of those
19 participating in these important human subjects protections
20 is needed.

21 Too often, those serving on the boards may not be
22 adequately informed of the boundaries of appropriate
23 scientific inquiry or even of the true function of the IRB
24 in terms of both science and ethics. The agency's role is
25 obviously one of education, as direct oversight at the

1 institutional level is impractical and probably unnecessary,
2 but education is warranted and could be coupled with the
3 material referenced earlier as part of a package of
4 curricula resources for health professionals in training and
5 practice. We stand ready to partner with the agency to
6 disseminate this information to pharmacists.

7 On maximizing the availability and clarity of
8 information for consumers and patients regarding new
9 products, you are the authoritative and independent source
10 of medical product information, but a source of information
11 typically provided through a pharmacist, physician, or other
12 health care provider, as the conduit to informing the
13 patient and the consumer.

14 Particularly for prescription medicines, the
15 interface between the health care provider and the patient
16 is essential to the appropriate use of these products, and
17 FDA, in addition to the efforts focused on providing
18 information directly to patients, should focus on ensuring
19 that health care professionals do have access to the most
20 recent information.

21 One example of an effective partnership to
22 communicate information to patients is the recent joint
23 publication by APhA and FDA of two patient brochures. These
24 two brochures, "Questions to Ask Your Pharmacist" and
25 "Making Your Medications Work Better," are available to

1 pharmacists and physicians across the country to distribute
2 to their patients, and will also be available through the
3 agency directly, through your public information resource
4 lines.

5 I think the agency does an admirable job in
6 issuing information to organizations like APhA through modes
7 of communication such as faxes, electronic messaging and
8 conference calls. With a number of approved products
9 increasing and important information on current products
10 emerging virtually every day, it is imperative that some
11 prioritization occur in the communication of information
12 from FDA to key stakeholders.

13 A suggestion that builds upon your current
14 practice is to codify a scheme, to clarify the importance of
15 new information. The most critical information would be the
16 subject of conference calls, a strategy you do use where
17 questions and answers are possible.

18 This information, as well as second-level
19 information needing rapid dissemination, could be
20 transmitted in an electronic form for quick addition to the
21 stakeholders web site.

22 Encouraging linkages between such sites on the
23 relevant page on the FDA web site is recommended and is
24 something that my organization does do currently on the most
25 important and timely information.

1 Fax transmissions are obviously fine when
2 information is not as timely or critical, and, thus, apt to
3 be published in weekly or monthly print publications.

4 Using a systematic process such as this would
5 allow the stakeholder groups to communicate to its audiences
6 that the most timely and important information is always
7 transmitted from the agency for dissemination to health
8 professionals.

9 On the inspection and post-marketing provisions of
10 the Act, all of us are aware of the steadily mounting
11 evidence of morbidity and mortality attributable to the
12 underuse and misuse of prescription medications. This
13 evidence has recently spilled over from its confinement in
14 medical journals to the lay media.

15 APhA is committed to working with the agency and
16 other stakeholder groups to design a knowledge system built
17 on voluntary reporting of post-marketing medication use
18 data. We don't believe a net new system is necessary or
19 necessarily that one internally developed to maintain by the
20 agency is the best use of limited resources. We would be
21 interested in developing a panel of pharmacists and other
22 health care professionals who would directly accept
23 responsibility for systematically providing information on
24 patient response to new products, particularly when those
25 products are ones associated with an unusual risk profile.

1 We have both the practitioners and scientists in
2 our membership to assist in the design and execution of such
3 a system.

4 To amplify on comments made last week at the CDER
5 hearing, the agency could help the situation by creating a
6 new classification system for prescription drugs under which
7 higher-risk products could be identified as belonging to a
8 category of drugs demanding special attention from
9 clinicians and patients. This is not a restatement of our
10 long-held position that a transition class of drugs is
11 warranted to expedite the reclassification of prescription
12 drugs to non-prescription status.

13 Instead, we believe that health professionals and
14 their patients would benefit greatly from the knowledge that
15 a drug in the high-risk category bears special or unusual
16 risks that require close monitoring.

17 Resources in monitoring should be directed to such
18 products to maximize the benefit of these expenditures as
19 well.

20 There are no simple recommendations for how the
21 agency can get their work done, and I didn't offer you
22 anything to take off of your list.

23 I won't repeat many of the other specific comments
24 presented on these and related items at the August 17th CDER
25 hearing, although I have attached a copy of that written

1 testimony to this testimony for ease of reference.

2 Thank you for offering us this opportunity.

3 DR. NIGHTINGALE: Thank you, Dr. Maine.

4 Are there any questions or comments from the FDA
5 panel?

6 Yes.

7 DR. FEIGAL: Two questions. One is, could you
8 comment on how the high-risk classification would differ
9 from products which currently have a black box, which have
10 special precautions with them?

11 Then, a question about something you did not
12 address. I guess we often look at the pharmacy as one of
13 the very vital steps in forcing recalls and withdrawals of
14 products. Do you have suggestions for how that system could
15 work better, and on your theme of developing communications,
16 how we could do better than we currently do, which seems to,
17 in many cases, track down from the manufacturer through
18 every middle man, down to the pharmacist as the last to be
19 notified?

20 DR. MAINE: Good questions.

21 I think there is a direct relationship probably
22 between the notion of the black box warning and the
23 classification system, although I think it goes beyond just
24 simply making sure that the information is available, and
25 largely its current print distribution, although obviously

1 that is going into other formats.

2 It really is--and we have not thought this through
3 in a systematic way by any stretch of the imagination, but
4 think it merits some serious evaluation by all of the
5 stakeholder groups because obviously that alone, the black
6 box warning system alone, is not sufficient to get
7 communicated to the audiences of interest that this is a
8 product or product category that needs special attention and
9 perhaps special monitoring post-marketing.

10 So, again, no easy answers or ones that we have
11 thought systematically through at this time. Just hope to
12 elevate that to the agency's consideration.

13 I think that the recall system breaks down largely
14 at the point that you mentioned in getting the information
15 about the most critical recalls out to the people who are
16 probably at the closest patient interface, certainly at the
17 point of distribution of that recalled product.

18 Again, I think it is an issue of prioritization,
19 not that the classing system of recalls--it does not
20 necessarily address this already. I think it is also fully
21 commanding the electronic architecture of information
22 transmission.

23 We are, for instance, as an organization about to
24 implement a new membership database system that will for the
25 first time ever give us the opportunity to broadcast

1 electronic messaging.

2 Now, that assumes that, as was referenced
3 previously, the people on the other end are able to pick up
4 those messages, and even though most pharmacies are
5 computerized, that is not a given.

6 DR. NIGHTINGALE: Other questions or comments?

7 Yes, Sharon.

8 MS. HOLSTON: Lucinda, if you could expand just a
9 little bit on the role that you saw in adverse event
10 reporting for the pharmacists and how that could link into
11 or replace or the system that we are currently trying to
12 build.

13 DR. MAINE: I think the biggest difference in our,
14 again, very preliminary thinking is that the voluntary
15 systems today depend on the universe of providers taking in
16 the initiative to send in the information, and those systems
17 have served us well to the extent that we have used them.

18 My thought is--our thought is based on the notion
19 that there probably is a highly motivated group of
20 practitioners that we could tap deliberately for reporting,
21 and particularly not on every single product that crosses
22 their practice, but on these products that perhaps we
23 classify as those that warrant special attention.

24 We have had some limited experience with
25 pharmacists engaged--community-based practitioners engaged

1 in phase three and four testing of products, as well as in
2 multi-year outcomes research initiatives, and we know that
3 once they have accepted the responsibility for that level of
4 patient care and data collection and transmission that they
5 do an excellent job. So it is an adaptation of that
6 thought, that rather than depending on all practitioners,
7 perhaps there is the right size of a panel of practitioners
8 that we would charge explicitly with and incent and motivate
9 in some way to get part of this work done more effectively.

10 DR. NIGHTINGALE: Thank you.

11 Any other comments or questions?

12 [No response.]

13 DR. NIGHTINGALE: If not, thank you, Dr. Maine.

14 Now I will turn to Dr. Mohammad Akhter, the
15 American Public Health Association.

16 DR. AKHTER: Thank you, Stuart.

17 My name is Mohammad Akhter. I am the executive
18 director of the American Public Health Association. We are
19 55,000 members in the United States, work at the Federal,
20 State, and county levels. So we are the people who make
21 sure the air is clean, the water is safe, food safety, and
22 when a disease outbreak takes place, we know how to immunize
23 people. It is so good to see so many friends and colleagues
24 from my previous life and my current life.

25 I want to briefly make three or four points, very

1 specific. The first point is we are also headquarters of
2 the World Foundation of Public Health Associations to which
3 58 countries belong. So we are very interested in
4 international health.

5 Health for the American people cannot be protected
6 without looking at the global health. We are becoming part
7 of a global village, and there are two or three very
8 critical items in that area that relate directly to FDA that
9 I want to bring about.

10 The first, of course, we all want to see that
11 there is some kind of a uniformity. We want to proceed, but
12 we do not want to lower the standards. I mean, clearly, all
13 my colleagues here, the speakers before me, have said that.
14 We do not want to lower the standards.

15 Second, there is now sale of drugs on the
16 Internet. That zig-zags all rules, regulations, countries,
17 and so on and so forth, where you may have very stringent
18 rules, but nobody cares for it. Anybody can buy drugs on
19 the Internet, and the drugs go back and forth. People buy
20 and sell, and we need to really take action on that one.

21 Dr. Stuart, I know you have been working with
22 other organizations that really do that.

23 The third part is really the availability of the
24 drugs internationally to control the disease. There are
25 some areas where the medication is not available or the

1 third world people simply cannot afford it.

2 Now that the FDA has particularly a specific role,
3 but it certainly can encourage. I will give one example.
4 The tuberculosis that is becoming so prevalent in our
5 country, also here, particularly drug-resistant TB, there
6 has not been a drug on the market in the past 20 years, a
7 new drug. These are the kinds of things where somebody
8 really needs to say, "Wait a minute. We need to really
9 encourage that."

10 The last point on the international is that food
11 right now has become an international commodity. We import
12 a heck of a lot of food. It comes in. It gets mixed with
13 the local things, and unless we play a critical role in
14 international affairs, we are not going to be able to
15 protect the health of the American people. So I suggest to
16 you to do two things.

17 First, look at the FDA structure and establish an
18 international group within the FDA, a section, center,
19 whatever you want to call it. I do not really mind about
20 this, but there must be a focus.

21 Second, appoint an advisory committing consisting
22 of people who can give you advice as you go and negotiate
23 with these international people of your statutes, so that
24 you go prepared pretty much from home and you go out and you
25 do your work.

1 Let's come to domestic. I want to really very
2 much thank the FDA, commend the FDA for its work on smoking
3 and food safety, on vaccines and many, many other areas
4 where FDA has done a heck of a job in protecting the health
5 of the American people. A lot of work has gone on, and it
6 is unfair not to stand up and say what is right and what is
7 new to the professional folks who work so hard.

8 We all can do more. There is not a single person
9 sitting in this room who has more money than they can spend.
10 So what we need to do within the FDA is to set the
11 priorities, and we must have an organized mechanism within
12 the FDA to setting the priorities so we can live within a
13 budget. We do the most important thing to protect the
14 health of the American people first, and then go down the
15 line.

16 I don't have any specific things. I can't say
17 this is good for my organization or this is good for
18 somebody else's organization, but you use your advisory
19 committees. Help them prioritize, and you go down the list.
20 When you can get things done that need to be done, then you
21 take them to the Congress. It is no sin to take it back to
22 the representatives of the American people and say we need
23 more money.

24 You will find us standing by your side in saying,
25 "Yes, these folks do need some money to protect the health

1 of the American people."

2 The third thing I want to say in this arena very
3 quickly is an area of professional and public education,
4 which I think is a fundamental key to the use of all the
5 good drugs and products that you all approve if they are not
6 used appropriately, adequately, and the public does not
7 understand. We might be wasting a lot of our resources, and
8 that needs to be strengthened.

9 So, from a regulated standpoint, public health,
10 professional education and public education should be one of
11 your main areas of strength, and you need to do this in
12 collaboration with the private sector.

13 Do not feel yourself that as FDA that you have no
14 reason to talk to the other people, that you have conflict
15 of interest. That is not true.

16 Look at CDC. CDC has a CDC foundation. We are
17 the private foundation that puts in the money so the CDC
18 will do things that it cannot do with Federal funds.

19 FDA needs to look at establishing an FDA
20 foundation or some other name. You pick the name. The name
21 is not important.

22 Ask all of us sitting on this side of the room and
23 sitting out in front of me to come down and help you fill
24 the coffers in some way so we can do the adequate job of
25 public education and professional education.

1 The third piece I want to way in this public and
2 professional education is the area where I think all
3 professional organizations, when they do their continuing
4 education, that FDA ought to be part of it. You should help
5 to strengthen Dr. Stuart's office as a medical director, as
6 a professional education person, who is always in contact
7 with the nurses, with the physicians, with the pharmacists,
8 so that no matter whose meeting it is, there is a session by
9 the FDA where you put forth your good work, where you put
10 forth the important things that are important to these
11 folks, so that no meeting ought to be without the FDA
12 session in those meetings, and many of the other Federal
13 organizations do that.

14 I conclude by saying that there is a lot of ground
15 to be gained, and I used to work for the Federal Government.
16 By working together with other agencies and other
17 organizations, and particularly I will name two that are
18 within HHS and particularly within the Public Health
19 Service--one of them is CDC. The other one is Health Care
20 Financing Administration.

21 They have a vast network of people, communication
22 resources, and all you need to do is to provide them the
23 information. Think about the information going to the
24 patient through the Medicaid/Medicare program. Think about
25 the information going to the doctors through the

1 Medicaid/Medicare program. Think about the information
2 going to the hospital and the clinics through
3 Medicaid/Medicare program. Think about the information
4 going to the public health departments through CDC. Think
5 about the information going to the medical education,
6 teaching places. There is a whole host of networks, and FDA
7 needs to really shake hands with those folks, take advantage
8 of those resources, and hopefully working together, we can
9 get on the ground this big, big responsibility that you all
10 have.

11 I wish you the very best to the FDA. Thank you.

12 DR. NIGHTINGALE: Thank you, Dr. Akhter.

13 Are there any questions or comments?

14 Bob?

15 MR. LAKE: Yes, Dr. Akhter. You mentioned in your
16 presentation a growing concern about food safety worldwide
17 and foods coming into this country which are increasing. Do
18 you have any specific suggestions beyond having a
19 strengthened international activity at FDA?

20 DR. AKHTER: Yes. We surely have very specific
21 suggestions. We have told the Congress and we have told the
22 White House that we support a single food agency, an agency
23 that has all the responsibilities to assure that the food
24 going to the American people is safe. And this agency ought
25 to be FDA. That has the regulatory authority, has the

1 muscle, and is given the resources to be able to carry it
2 out, without any conflict of interest.

3 One of the things that we think that even we are
4 in this kind of difficulty is the division for
5 responsibility of food safety among 12 different agencies of
6 the Government. We think the time has come to consolidate
7 those and at least have one person responsible and
8 accountable to the American people.

9 DR. NIGHTINGALE: Other comments or questions?
10 Susan?

11 DR. ALPERT: employees. We are very interested
12 clearly in harmonization and in working with other
13 countries, and you mentioned strengthening the international
14 effort, but I do not think I heard the areas in which you
15 thought that strengthened or that special work might be
16 done.

17 DR. AKHTER: I think part of it is to strengthen
18 with the other regulatory agencies like yourselves and other
19 countries so that you have the same kind of rules and
20 regulations that we have here, make sure that we have a
21 common mechanism worked out, deal with Internet access to
22 drugs, make sure that we have the processes of ongoing
23 negotiations. So, whenever the issue comes in, that we can
24 take it someplace and have it resolved within the
25 international community, and that you do that by consulting

1 with the domestic organizations that have a vested interest.

2 So there could be an advisory committee at home
3 that can give you advice on an as-needed basis so that you
4 go prepared to deal with other organizations.

5 DR. NIGHTINGALE: Other comments from FDA?

6 [No response.]

7 DR. NIGHTINGALE: If not, thank you, Dr. Akhter.

8 Our next presenter is Dr. Gary Dennis who will be
9 representing the National Medical Association.

10 DR. DENNIS: Good afternoon. I am the president
11 of the National Medical Association which represents 22,000
12 predominantly African-American positions in the United
13 States and U.S. Territories.

14 We have altogether about 132 small societies which
15 are at local levels and State levels around the country, and
16 we focus a lot of our attention on public health of our
17 citizens, but particularly the underserved, the poor, and
18 ethnic minority communities, especially African Americans.

19 We are an organization which is 103 years old, and
20 in fact, we were the only national medical organization to
21 support Medicare and Medicaid in 1964 and '65, so that we
22 have been outspoken on many issues related to the public
23 health, but we also have a number of scientific sections
24 which review from time to time health policy as it relates
25 to various pharmaceuticals, over-the-counter drugs,

1 prescription drugs, in addition to medical devices.

2 We also from time to time develop positions on
3 them after reviewing them through our scientific sections,
4 so that we are very pleased to have this opportunity to
5 speak today regarding this particular issue as a
6 stakeholder, the implementation of Section 406(b) of the FDA
7 Modernization Act of 1997.

8 I would like to also note that we have an interest
9 in international health. In fact, we have not only
10 International Health Affairs Committee. We have physicians
11 that are in Nairobi as I speak delivering necessary supplies
12 and pharmaceuticals, and will be going on to Tanzania later
13 this week to do the same. So we also have an interest in
14 the global use of products as it relates to the FDA and the
15 FDA's involvement or lack thereof.

16 The FDA focus on adverse reporting, product safety
17 assurance, product application reviews, food safety
18 outreach, scientific infrastructure and research in tobacco
19 is a comprehensive approach and requires the full
20 cooperation of the health care and especially physician
21 community, private industry and consumers.

22 In order to improve the understanding of the
23 review process, more information should be available to the
24 public and physician community. The physician community,
25 you have to remember, are doctors that are practicing every

1 day that don't spend a great deal of time reading books.

2 They do read journals and attend meetings
3 periodically, but don't have the benefit of intensive
4 information regarding especially new medical devices and
5 pharmaceuticals, and need continuing education, especially
6 as it relates to what the FDA feels is very important, along
7 with private industry and the consumers.

8 So, in order to improve the understanding of the
9 review process, more information should be available so that
10 the burden on Government and industry is clarified as well
11 as there is a way to have input into the process so that it
12 can be accelerated or extended when outcomes and clinical
13 needs warrant it.

14 The message can be articulated in a newsletter in
15 web site with hot links. We have a web site. In fact, I
16 have heard other comments about that. We feel that a hot
17 link to our web site would also give us immediate indication
18 as to a problem, and that everyone who is hitting our web
19 site would also get that information, and the message could
20 get out really to all stakeholders with periodic updates, as
21 was stated previously.

22 New product information could be and should be
23 reviewed by focus groups and stakeholders with a common
24 period in allowing time for refinement and clarification of
25 product information. Sometimes it is hard to know how

1 effective that information is at delivering the message, but
2 including more stakeholders and having more opportunity to
3 review, the information that is available, I think, would
4 improve the use of various drugs and devices, as well as
5 prevent a lot of the unfortunate mishaps that occur due to
6 misinformation or a lack of understanding.

7 The newsletter and web site could be used to
8 request comments as well, as well as to inform stakeholders
9 about the final information format, if there has been a
10 change, and this is just routine information.

11 In order to improve the post-marketing
12 surveillance system, periodic requests for comment regarding
13 comments being used in different disease groups may be
14 requested to determine if there is a need for more than
15 periodic intensive review, again, echoing a previous comment
16 about there being a group who can periodically review if
17 something is coming up which had not been anticipated, and
18 this may be a few isolated reports. Then you have a focus
19 group of reliable clinicians and researchers who can give
20 you immediate feedback because that is really what is
21 required. And today, it generally takes often years in
22 order to get the message back when a message really needs a
23 very prompt reply.

24 So, as part of the periodic intensive review, the
25 minimum standards should be used to approve a product--I

1 mean, used to approve a product, should be reviewed in light
2 of current technology as well.

3 So that, in fact, if there is some breakthrough
4 and standards are antiquated that were used to approve
5 previous products, then immediately those new breakthroughs
6 should be applied to the products which are in use to
7 determine whether there needs to be some changes made.

8 The requests may come to the stakeholders with
9 adequate time for review by constituencies so that comments
10 will be meaningful. So, again, if you need a wider base of
11 review, you do not just need your focus group that you have
12 been using periodically. Allow a comment period which is
13 longer so that information can be disseminated through
14 organizations, and a wider response be obtained. That also
15 is a good way to inform. The FDA has been good in informing
16 the physician community when there is a specific crisis, but
17 when there is a focussed area, often that information is
18 only given to some practitioners and not to the larger
19 group.

20 So a two-way communication will allow for
21 unsolicited comments from stakeholders that will also help
22 identify early risk to the public. So that, if you have as
23 part of this communication an opportunity to provide
24 unsolicited comments, then things that you did not think of
25 before that may be significant can begin to be considered

1 quickly.

2 In order to improve the scientific infrastructure,
3 direct appeals to medical associations, universities, and
4 private industry should occur for needed expertise.
5 Currently, that does occur.

6 I know that in the formulation of panels--but that
7 probably should be done more extensively, and certainly our
8 medical association and others could certainly be helpful.

9 Using a regular communications vehicle, these
10 requests can also be distributed. So that, if you know you
11 need 50 clinical pharmacists or pharmacologists to carry out
12 a certain survey or study, that you can begin to disseminate
13 that information widely throughout the community, and you
14 may get a much larger response more quickly.

15 There should also be adequate Federal
16 appropriations to carry out the full responsibilities of the
17 FDA, regardless of whether there are user fees. In fact,
18 that should not be an excuse at all for protecting the
19 public or not protecting the public.

20 In addition to the outlying areas, comprehensive
21 product review should be undertaken to determine the
22 adequacy of applications which have an impact on diverse
23 populations, including women and ethnic minorities and the
24 product's reliability and the presence of c-morbidities,
25 which may enhance drug-drug interactions or negatively

1 impact the co-morbid conditions; for instance, patients who
2 are treated with medications that as a side effect lower
3 blood pressure, but patients who are significantly
4 hypertensive when such medications are given, they have an
5 adverse effect in lowering the blood pressure, when, in
6 fact, that was an undesirable effect. Therefore, the co-
7 morbid state is adversely affected, and the patient does
8 much worse.

9 For instance, in the African-American community,
10 central hypertension is very common, and there are many
11 drugs that have that sort of impact.

12 Another example would be a patient who is being
13 treated with often over-the-counter drugs, but these drugs
14 that are prescribed by a physician and then the patient goes
15 on and continues to over-utilize them, and then the effects
16 of that particular drug has a significant adverse effect on
17 the patient as a consequence of side effects that interact
18 with drugs that are needed for other diseases that are under
19 treatment that are prescription drugs.

20 So, by more thoroughly understanding the potential
21 interaction of new products on clinical outcomes, adverse
22 reactions may be significantly reduced. Certainly, the
23 public is not aware of the effects of many of the
24 over-the-counter drugs, their long-term effects, and
25 certainly more attention especially in relationship to the

1 drug-drug interactions should be given.

2 The areas of concern are numerous and require
3 frequent evaluation. We are on the verge of a new
4 millennium where a genetic fingerprint will be as common as
5 a CBC, where cloning certainly will become a reality of
6 humans and have an impact on all of us. So that, we, the
7 National Medical Association, would like to work as a true
8 partner, along with other stakeholders, and look forward to
9 providing comments in the future, and we are grateful to
10 have the opportunity today to comment on the implementation
11 of Section 406(b) of the FDA Modernization Act of 1997.

12 Thank you.

13 DR. NIGHTINGALE: Thank you, Dr. Dennis.

14 Yes, Sharon.

15 MS. HOLSTON: Dr. Dennis, you speak to the issues
16 of better understanding the differences about how drugs work
17 in different populations, and one of the things that the
18 agency has grappled with is the whole issue of greater
19 inclusion of minorities in clinical trials.

20 It is sort of different from the issue about women
21 where women historically were excluded. In this case,
22 sometimes minorities had been included in trials that we
23 would prefer they not be included in, but by the same
24 token--and as a result of that, there appears to be some
25 reluctance, very often on the part of minorities to

1 participate in clinical trials because of suspicions about
2 being used as guinea pigs, et cetera.

3 We have made an assertive effort to try to educate
4 about greater participation in clinical trials, and I would
5 appreciate any ideas or suggestions you may have along those
6 lines.

7 DR. DENNIS: That is a major concern of the
8 National Medical Association, and in fact, with all of the
9 significant health care disparities that affect African
10 Americans, the answers are partially in access to health
11 care because there is a significant number of under-insured
12 and uninsured African Americans, but in addition to that,
13 the answers in many instances are related in clinical
14 trials, especially when the co-morbid conditions, where a
15 dosage may be an issue or, in fact, a drug may not be
16 effective.

17 Usually, that is not the case. Usually, there are
18 co-morbid factors that are contributed to by the lack of
19 health care that make the situation fruitless. However,
20 clinical trials are very important, though, to identifying
21 what the true answers are, and also developing new
22 treatments that work better.

23 The National Medical Association intends to have
24 an annual clinical trials course at our annual convention,
25 and it will be a turnkey type of course that will allow us

1 to educate clinicians to participate in clinical trials, as
2 well as to train coordinators.

3 One of the big problems in our own community is
4 that the physicians and clinicians are not as aware of how
5 they can participate, and in fact have not been advocating
6 as much as they should with patients, but by training them,
7 we should overcome some barriers in relationship to that,
8 but also in developing partnerships.

9 Part of our curriculum will focus on how to
10 recruit African-American patients. We know that there has
11 to be a triad. You have to involve the doctor of the
12 patient. You have to involve the family of the patient, and
13 you have to involve the patient, which means that a
14 different approach to it, where the patient's family can see
15 the benefit or the patient can see a benefit to the family
16 of participating makes a difference.

17 I think that the NMA would certainly be interested
18 in working with the FDA in relationship to increasing the
19 participation of African Americans and other
20 under-represented minorities in clinical trials, and we look
21 forward to, in fact, sharing our activities with you.

22 DR. NIGHTINGALE: Thank you.

23 Any other questions or comments?

24 Debbie?

25 MS. HENDERSON: Dr. Dennis, you were just recently

1 talking most recently about the drug-drug interaction
2 problem, and you mentioned, I think, quite astutely that we
3 need to make the public more aware of the interactions,
4 especially with the over-the-counter drugs that they are
5 taking. Do you think that that attention needs to be
6 directed more at the public, that we need to be providing
7 more information by the label of the OTC products, or do we
8 need to be focussing more attention on the health care
9 providers and the information that they are providing to
10 their patients about the interactions with their medicines?

11 DR. DENNIS: Actually, both need that information.

12 MS. HENDERSON: I was afraid you would say that.

13 DR. DENNIS: I will tell you, though, the patients
14 themselves certainly need to know what the long-term effects
15 of a lot of these over-the-counter drugs are. They have no
16 idea.

17 A lot of these drugs were prescription drugs just
18 a couple of years ago, and they seemed to be relatively safe
19 drugs at the time, but now we are beginning to see patients
20 over-utilize them in ways that doctors would never have
21 prescribed them. And as a consequence, the side effects are
22 much worse and patients really do not have a clue that that
23 would happen.

24 I think that doctors also have been assuming the
25 same thing oftentimes. Well, our prescription is no longer

1 required. This must be fairly safe now. You know, maybe
2 the doses is safer. And doctors don't necessarily know
3 that, well, it really is the same thing, the same drug, same
4 problems, and they see it much later as a consequence and do
5 not warn patients as much.

6 Often, when you ask a patient what medicine they
7 are taking, they do not even mention the over-the-counter
8 drugs because they do not consider them medicine. So I
9 think that a lot of the issues are really to be directed
10 toward consumers with labeling, et cetera, but we also need
11 to incorporate that into education process of practicing
12 physicians and medical students.

13 DR. NIGHTINGALE: Thank you.

14 Any other comments or questions?

15 [No response.]

16 DR. NIGHTINGALE: If not, thank you, Dr. Dennis.

17 Now we turn to Dr. Sanford Chodos, who is
18 representing the Public Responsibility in Medicine and
19 Research, better known as PRMAR or PRM&R.

20 DR. CHODOSH: I am last, but I hope not least
21 because I believe that I am representing a group which
22 really has not been discussed by all the other folks,
23 although their comments were, I think, excellent, and I will
24 not try to repeat them.

25 You have heard my name. You should know that I am

1 a Federal employee. I work for the VA. I empathize,
2 therefore, with the FDA in that we are also facing similar
3 challenges of how to reorganize and do more with less, but
4 here today I am representing the group called Public
5 Responsibility in Medicine and Research.

6 If you ask me about our membership, we have no
7 membership. We are a board of 28 people who do this for our
8 love of what we do, and we never had a membership because we
9 felt that we did not want to get into taking sides.

10 We are a non-profit organization that is involved
11 with IRB affairs, IRB meaning institutional review boards.
12 We have been responsive to NIH and FDA as a sounding board
13 for new or changes in regulations and policies concerning
14 ethical and practical aspects of institutional review board
15 functions, and provide a forum in our many conferences. And
16 we have now gone over 60 in our 25 years or so of having
17 such for individuals involved with institutional review
18 board affairs. We also run similar ones for those involves
19 with research with animals.

20 I am pleased that we are here represented as
21 stakeholders.

22 My other credentials are that I have been an IRB
23 chairman for--or had been for 11 years in a very active
24 institution, and have been an active investigator of
25 pharmacologic agents in the area of pulmonary medicine and

1 infectious disease, well over 30 years. So I have had
2 dealings with just about all aspects of this business.

3 I will address a few areas of concern, but my
4 overall concern remains with the protection of human
5 subjects. We have forgotten in all of this that for any of
6 this to be happening that we are involving a huge number of
7 human subjects, most of whom are not paid, some of which
8 receive some compensation, but most do it with the idea that
9 this is something that they can do to advance science or to
10 feel worthwhile in whatever their disease problems are.

11 I just want to make a few comments in areas of
12 concern. One is that IRBs are notoriously overextended in
13 their responsibilities. At the present time, I would say
14 that most are not appropriately staffed or funded to
15 accomplish their responsibilities. It is hard to--we will
16 get to perhaps how we can solve that.

17 Additional demands, currently to review all severe
18 adverse events called SAEs for multiple sponsors is of
19 questionable value and a huge burden on an IRB who takes
20 their work seriously because sponsors tend to over-report.
21 I do not know why. I think for legal purposes. And they
22 also will provide multiple confusing descriptions of the
23 same cases. They rarely will provide opinions, and the IRB
24 is now accumulating these at a vast rate.

25 Some large institutions have rooms full of such

1 events without much coming out of them. These really do not
2 necessarily protect the human subject very much, and I think
3 it diverts IRB functions.

4 I think that the FDA should insist that
5 institutions that approve research and protocols that have
6 FDA concerns in them, that there is adequate support for the
7 IRB functions, but otherwise the human subjects are really
8 not being protected very well.

9 The regulations carefully outline who has to be on
10 the IRB board itself. They also imply that the functions
11 should be supported. However, this is not supervised to my
12 knowledge in any meaningful way.

13 Number two, the FDA, I am afraid, has been
14 responsible for creating a new thing, a number of years
15 back. They have allowed the local control of research which
16 for many years was the responsibility of the institution to
17 be largely replaced by non-local and non-institutional
18 review and supervision. These are called central review
19 boards.

20 One must question the ability of a distant review
21 board to have intimate knowledge of the capability of the
22 investigator other than a CV or curriculum vitae which they
23 might present, and to assess that all aspects of the
24 protection of human subjects are in place.

25 I have never heard a good argument that says that

1 that will work well. This has been, I think, put forward
2 mostly by sponsors because it makes it much easier for them
3 to get their research done, and has over the years involved
4 more and more non-investigators, frankly, who are contract
5 workers, in essence, who are compiling large amounts of
6 information and whose work is not part of any institution or
7 any academic endeavor.

8 Number three, the FDA should insist that sponsors
9 provide the outcomes, final reports of the studies to the
10 investigators that they were involved with, and also to the
11 institutional review boards and to the subjects that
12 volunteered and took the risk to be in the study. This
13 never happens spontaneously, and often is not achieved when
14 requested. Many companies will even balk at breaking the
15 code of a double-blind study so that you will know what the
16 subjects have received. I think this is unacceptable, but,
17 however, goes on all the time.

18 Number four sort of ties in with this, and that is
19 that publications of IRB-approved investigations are often
20 market-driven and determined by the sponsors. Studies that
21 are marginal or negative to the product rarely, if ever, get
22 published. This is particularly easy to manipulate in
23 multi-center studies.

24 This raises real concerns about the ethics of
25 involving subjects in experimental studies for which there

1 is no advancement of knowledge.

2 Five, sponsors do not reveal prospective
3 investigators or their institutions any negative comments or
4 results of reviews by other institutional review boards.
5 This is particularly true in device research, I should say.

6 In fact, there should be a registry for each
7 protocol as to the various IRBs reviewed so that subsequent
8 IRBs that review these protocols would have knowledge of the
9 problems and concerns that were previously noted.

10 I thank you for permitting me to address this. I
11 will try to be short since I am the last, and I think I
12 stuck to my time.

13 Thank you.

14 DR. NIGHTINGALE: Thank you, Dr. Chodosh.

15 Are there any questions or comments for him?

16 [No response.]

17 DR. NIGHTINGALE: No? Well, in that case, we are
18 a little bit overtime, but, first, I want to thank the
19 panelists for really generally sticking to their time. I
20 think this is terrific. There was a tremendous amount of
21 information and very good advice. So this accomplished
22 precisely what we wanted to accomplish with this first
23 session.

24 We are going to take a 10-minute break, and then
25 we will reassemble.

1 May I just see, are there any other requests for
2 speakers beyond the five that are listed on the current
3 agenda? That will determine, as I said earlier, somewhat
4 how we do this.

5 If not, why don't all the people who have asked to
6 speak in the afternoon come up and in 10 minutes be present
7 here, and the FDA panel will also be assembled at the same
8 time.

9 Thank you.

10 Let's return at about quarter past 3:00.

11 [Recess.]

12 **Presentations by Health Professional Organizations**
13 **and Individuals**

14 DR. NIGHTINGALE: I would like to get started. I
15 know there are some people that are still lingering in the
16 hall, but it is important to try to keep on time.

17 We have one addition to those that are already
18 signed up, and I think I would ask that person to come up
19 here and sit down as well to be part of the panel. It is
20 Mr. John Isidor who is representing the Consortium of
21 Independent IRBs.

22 I also want to remind you before beginning that
23 this meeting taking place on September 14th, the
24 stakeholders meeting mentioned before, there will be an
25 agency-wide, cross-agency themes. It will be at the

1 Bethesda Holiday Inn, Monday, September 14th, from 9:00 a.m.
2 to 5:00 p.m.

3 I think given where we are in terms of time, what
4 we will do is just have each presentation and then ask the
5 FDA reactor panel to comment or ask questions right at that
6 point. I would like to try to keep us on time. I think it
7 is possible.

8 The first presenter will be Dr. James Callahan,
9 representing the American Society of Addiction Medicine.

10 DR. CALLAHAN: Thank you, Dr. Nightingale.

11 I want to first thank Drs. Sharon Smith Holston
12 and Stuart Nightingale and the staff of the FDA for hosting
13 the open forum and for providing time for comment from
14 interested and concerned organizations.

15 The American Society of Addiction Medicine is a
16 not-for-profit medical specialty society of 3,200 physicians
17 engaged in prevention, research, treatment, and medical
18 education for alcohol, nicotine, and other drug dependencies
19 and related medical consequences, such as HIV/AIDS.

20 ASAM recognizes and gratefully acknowledges the
21 outstanding work the FDA has done in areas of concern to our
22 members and urges the FDA to expand its endeavors in four
23 areas.

24 First, nicotine and tobacco. Despite efforts in
25 the Nation to the contrary, ASAM urges the FDA to continue

1 to do everything it can under its authority to regulate
2 cigarettes and smokeless tobacco products as nicotine
3 delivery devices.

4 ASAM in particular urges the FDA to continue to
5 control the availability of tobacco products to the young
6 through the establishment of an enforced national minimum
7 age of 21 years for purchase. Punitive approaches should be
8 reserved to manufacturers, distributors, and merchants, and
9 should not include measures that penalize underage
10 possession or use of tobacco products.

11 ASAM also urges the FDA to require tobacco product
12 manufacturers to public and publicize the ingredients in
13 each brand and the level of toxic substances, including
14 nicotine.

15 Second, medication development regulation and
16 scheduling. ASAM promotes the development and proper
17 regulation and scheduling of new medications which have
18 application in treatment of addictive disorders. ASAM urges
19 the FDA to join forces with the National Institute on Drug
20 Abuse and the pharmaceutical industry to develop new drugs.

21 We also urge speedy approval for drugs currently
22 under review for approval. We have a specific request
23 regarding bufotenine, namely that the FDA collaborate with
24 the medical community, the Drug Enforcement Administration,
25 and others to assure that Federal-controlled substance

1 scheduling guidelines and other Federal and State
2 regulations will permit butylamine to be made available for
3 physicians to prescribe to their patients in accordance with
4 documented clinical indications, and that physicians
5 appropriately trained and qualified in the treatment of
6 opiate withdrawal and opiate dependence should be permitted
7 to prescribe butylamine in the normal course of medical
8 practice and in accordance with appropriate medical practice
9 guidelines.

10 Thirdly, methadone. Many ASAM members work in
11 opiate addiction and methadone maintenance therapy. While
12 methadone program certification is becoming the
13 responsibility of the Center for Substance Abuse Treatment,
14 ASAM urges the FDA to make available to CSAT the wisdom and
15 expertise that the FDA has acquired in its many years of
16 experience in this area.

17 Secondly, ASAM urges the FDA to become a close
18 partner with CSAT, the members of the medical community, the
19 members of the methadone treatment community and others to
20 make methadone treatment therapy more widely available for
21 stabilized chemically dependent individuals by making
22 methadone maintenance part of mainstream medical practice
23 through the newly proposed office-based opioid therapy
24 program.

25 Finally, needle exchange. Needle exchange

1 programs are a crucial component of a spectrum of HIV
2 prevention services which effectively reduce the
3 transmission of the HIV virus by drug injectors. ASAM
4 recommends that the FDA do all within its authority to
5 assure that needle exchange programs are furthered and that
6 research on these programs is also developed.

7 I will provide you with a copy of the remarks I
8 have just made, and also a copy of our policy statements
9 bearing on them.

10 Thank you very much.

11 DR. NIGHTINGALE: Thank you, Dr. Callahan.

12 Are there any questions or comments from the FDA
13 panel?

14 [No response.]

15 DR. NIGHTINGALE: Thank you.

16 Then let's go on to William Zellmer who will be
17 representing the American Society of Health-System
18 Pharmacists.

19 MR. ZELLMER: Thank you, Dr. Nightingale. We
20 appreciate the opportunity to be here.

21 Again, my name is William Zellmer. I am senior
22 vice president for the American Society of Health-System
23 Pharmacists.

24 ASHP is a professional society that represents
25 pharmacists who practice in the institutional environment in

1 the integrated system or health networks and the components
2 in those systems such as hospitals, outpatient clinics,
3 PPOs, long-term care facilities, and home care
4 organizations. We have 30,000 members. Our members are
5 responsible for both drug distribution control and for
6 clinical pharmacy activities.

7 I am going to limit my comments to two aspects of
8 agency efforts that are designed to ensure high-quality
9 products and consumer protection. These are two issues that
10 are of special importance to our members.

11 The first issue is the need for assertive actions
12 by the FDA to help prevent medication errors, and the second
13 issue is enhancement of the MedWatch program.

14 Prevention of medication errors. There is
15 abundant evidence that poor product design is a major
16 contributing factor in medication errors. Poor label
17 readability, poor nomenclature, look-alike and sound-alike
18 product names, confusing abbreviations, and a lack of
19 machine-readable barcoding are all examples of product
20 designs that contribute to errors.

21 These problems are getting worse because of the
22 high-stress environments in which a growing number of health
23 professionals practice. The projected escalation of
24 approvals of new drugs, biologicals, and drug-related
25 devices will also exacerbate the problem.

1 One authority has noted that 20 to 25 percent of
2 reported medication errors result from confusion that stems
3 from look-alike and sound-alike drug names.

4 Now, the FDA is well aware of these problems.
5 Almost exactly 2 years ago, one of these meetings with
6 representatives of health professional organizations was
7 devoted to the topic of medication errors. At that meeting,
8 an FDA speaker noted that the agency was considering some
9 specific proposals that would aid in remedying the product
10 design problems.

11 The most promising proposal, we believe,
12 contemplated a failure mode and effects analysis as part of
13 new drug application safety summaries.

14 Now, what has happened since that meeting, 2 years
15 ago? Apparently not much. Two participants at an FDA
16 meeting last January presented information on how to
17 minimize errors caused by similar drug names, but as of 2
18 weeks ago, when we checked with the agency, ASHP was
19 informed that it was still "considering its options."

20 Well, it is time to stop considering options and
21 take action. Patients are being harmed because of the
22 agency's inaction.

23 Before the FDA approves for marketing any new drug
24 or biological product, it should require the manufacturer to
25 document that it has rigorously tested all packaging and

1 labeling for their potential to induce errors. This testing
2 should be done using proven methods involving practicing
3 pharmacists, physicians, and nurses in a simulated work
4 environment.

5 Such failure mode and effects analyses have been
6 applied successfully in the nuclear power industry and in
7 aviation to help prevent small errors from becoming large
8 catastrophes.

9 We strongly encourage the FDA to require that this
10 proven technique be applied to drug and biological products.
11 Until the agency does so, it will be compromising its
12 responsibility in consumer protection.

13 Further, for the list of pharmaceutical products
14 currently on the market whose packaging and labeling have
15 been documented to cause errors, the FDA should initiate and
16 assertive process to require the manufacturers to make the
17 appropriate changes.

18 Let me turn to MedWatch. We understand that the
19 agency may be planning to increase substantially the
20 resources devoted to this important program. As it does so,
21 we encourage FDA to find a way to bring its MedWatch reports
22 to the direct attention of practicing pharmacists,
23 physicians, and nurses.

24 We also encourage the agency to increase its
25 analysis of MedWatch data and to bring to the attention to

1 health professionals practical advice on steps that they can
2 take to reduce problems associated with specific products.

3 In summary, ASHP believes that the agency should
4 play a larger role, a larger role in helping this Nation
5 improve the safety of medication use. The FDA readily has
6 at hand through its oversight of labeling and packaging in
7 the approval process and through the MedWatch program
8 powerful tools to achieve this goal, and we strongly
9 encourage it to use those tools.

10 Thank you very much for your attention. There is
11 a copy of my comments at the desk outside. Thank you.

12 DR. NIGHTINGALE: Thank you, Mr. Zellmer.

13 Are there any comments or questions from the FDA
14 panel?

15 Yes, Mike.

16 DR. BLACKWELL: Just a question regarding the
17 MedWatch reports.

18 Are the reports as currently written adequate as
19 just a matter of being made available to practicing
20 pharmacists, or are you suggesting a different kind of
21 report?

22 MR. ZELLMER: As a health professional society at
23 ASHP, we see on the Internet reports that are issued from
24 the MedWatch program. We think those reports are extremely
25 well done.

1 We do our best to get those to the attention of
2 practicing pharmacists, but we are limited in that capacity,
3 and we wish perhaps working together we could find a way for
4 the agency to get that directly in the hands of practicing
5 physicians, nurses, and pharmacists.

6 DR. BLACKWELL: Thank you.

7 DR. NIGHTINGALE: Thanks.

8 Any other comments or questions?

9 [No response.]

10 DR. NIGHTINGALE: Thank you, Mr. Zellmer.

11 Let's turn now to Dr. Bernadette Dunham from the
12 American Veterinary Medical Association.

13 DR. DUNHAM: Thank you very much.

14 I am representing the American Veterinary Medical
15 Association, which has 61,100 members, and I would like to
16 thank Dr. Holston and Dr. Nightingale for inviting me to
17 participate in this presentation.

18 The objective of the AVMA is to advance the
19 science and art of veterinary medicine, including its
20 relationship to public health, biological science, and
21 agriculture. The association provides a forum for the
22 discussion of issues of importance to the veterinary
23 profession and for the development of official positions.

24 The AVMA is the authorized voice for the
25 profession in presenting its views to Government, academia,

1 agriculture, pet owners, the media, and concerned public.

2 As health professionals, the majority of the
3 public know veterinarians in the context of treating
4 companion animals. However, veterinarians do play a very
5 key role in public health. Even our oath attests to the use
6 of our scientific knowledge and skills for the benefit of
7 society, through the protection of animal health, the relief
8 of animal suffering, the conservation of livestock
9 resources, and the promotion of public health in the
10 advancement of medical knowledge.

11 Actions that veterinarians take for animal health
12 protection affects directly or indirectly human health. For
13 example, we strive to protect the health of the public
14 against a variety of zoonotic agents, be they the
15 vaccination of your pet against rabies, to us treating the
16 cattle for brucellosis, to us striving to ensure that the
17 animal-derived food products are going to be safe for human
18 consumption.

19 As a concerned organization, the AVMA would like
20 to respond to some of the questions posed by the FDA and its
21 hard-working Center for Veterinary Medicine, which is under
22 the excellent leadership of Dr. Stephen Sundlof. Our
23 comments will also be submitted to the docket's management
24 branch of the FDA.

25 Let me share just a couple of them. In the first

1 general question, the FDA asks what it can do to improve its
2 explanation of the agency's submission review process and
3 make explanations more available to various parties.

4 This would seem to us, first time, to be a
5 question for the animal drug industry. However,
6 veterinarians are highly concerned with how the process
7 impacts on drug availability. Clear communication and
8 transparency of the process is paramount. Implementation of
9 the letter and spirit of the Animal Drug Availability Act,
10 particularly with respect to efficacy testing requirements,
11 binding pre-submission conferences, and minor use/minor
12 species approvals must be uniformly welcomed by the Center
13 for Veterinary Medicine.

14 Another question that takes a look at the
15 effective surveillance and compliance unit, these functions
16 are important to the AVMA. We desire ongoing and enhanced
17 support from the center to answer questions related to
18 extra-label drug use by veterinarians. Generally, these
19 questions involve agency's evaluation of a situation and
20 interpretation of regulatory policy.

21 With regard to correcting problems associated with
22 the USDA regulated products--with FDA regulated products,
23 the AVMA mentions an area of one concern, and that is the
24 illegal distribution of prescription drugs to end users
25 without authorization from a veterinarian involved in a

1 veterinary client-patient relationship. The AVMA would like
2 to see enforcement presence on this issue.

3 Given the recent focus on post-marketing
4 surveillance of antimicrobials used to treat food animals,
5 the AVMA feels compelled to state that while we
6 enthusiastically support improved antimicrobial
7 susceptibility monitoring programs, the goal must always be
8 the retrieval of useful and scientifically sound
9 information, with the recognition that the cost must not
10 become so prohibitive as to adversely affect drug
11 availability.

12 We also urge for transparent science-based
13 discussions with stakeholders as the agency embarks upon
14 evaluating results obtained from expanding monitoring
15 programs and determining any corrective actions. We look
16 forward to further participation in upcoming meetings on
17 this with the center.

18 A fourth question asked by the FDA was should they
19 ensure an appropriate scientific infrastructure with
20 continued access to scientific and technical expertise
21 needed to meet its statutory obligations and strengthen its
22 science-based decision-making process.

23 In this day and age of increasingly complex
24 scientific issues, it is imperative that the center does
25 have timely access to the best scientific expertise

1 available. This is the foundation of good decision-making,
2 and many times, it does, in fact, take more dollars. We
3 certainly would advocate increasing the FDA budget.

4 A fifth question asks about timely product
5 reviews, particularly in the absence of user fees. In the
6 AVMA's 1993 position, it stated that the AVMA supports user
7 fees for new animal drug applications only if such fees are
8 directed towards enhanced review and approval of animal drug
9 products.

10 It must be remembered, however, that the cost of
11 user fees will ultimately be recovered in the purchase price
12 of a drug.

13 And for the livestock and poultry industries,
14 higher cost of drugs can offset the benefit of improved drug
15 availability when the producers cannot afford to use these
16 drugs. Thus, the user fee is not really a panacea, and in
17 addition, it should not be a mechanism for deficit
18 reduction.

19 Internationally, this is an area that the Center
20 for Veterinary Medicine is certainly faced with a lot of
21 aspects, and we at the AVMA support this. We are looking at
22 international standard-setting in the establishment of
23 veterinary drug residue standards. We need to harmonize
24 veterinary drug registration requirements, and we are hoping
25 to work with the agency on developing mutual recognition

1 agreements between the U.S. and other nations.

2 Any more of this transparency is crucial if we are
3 going to be able to ensure these high standards that we want
4 to protect public health.

5 I wish to thank you for this opportunity to
6 comment on behalf of the AVMA and remind you of the standing
7 invitation to use organized veterinary medicine as a
8 resource in your decision-making and a conduit for your
9 message.

10 We, too, have a web site, and I believe this is
11 going to become more and more of a way to transmitting to
12 our members, and we also offer, as you have heard earlier,
13 similar ways of communicating to the members to make them
14 aware of the issues.

15 Thank you very much.

16 DR. NIGHTINGALE: Thank you, Dr. Dunham.

17 Any questions or comments from the FDA panel?

18 [No response.]

19 DR. NIGHTINGALE: Thank you.

20 Then we will go on to Ray Bullman, who is
21 representing the National Council on Patient Information and
22 Education, better known as NCPPIE.

23 MR. BULLMAN: Thank you for the opportunity to
24 comment today.

25 The National Council on Patient Information and

1 Education, NCPIE, of which the Food and Drug Administration
2 is a founding member, is pleased that the agency is seeking
3 input into how it can help assure that health care
4 professionals and consumers get the information they need
5 about their medicines and other medical products.

6 This objective is similar to NCPIE's mission,
7 which is to stimulate and improve communication of
8 information on the appropriate use of medicines to consumers
9 and health care professionals.

10 My comments today are an extension of those I
11 presented at the CDER stakeholders meeting on August 17th of
12 this year.

13 NCPIE is concerned about the quality and the
14 quantity of information being conveyed to patients as
15 adjuncts to direct-to-consumer ads, at the point of
16 prescribing, and as supplemental written information
17 provided to information with their prescription medicines at
18 the pharmacy, or in the mail for that matter.

19 As we suggested in written comments to the agency
20 last October in response to its draft guidelines for
21 industry, consumer-directed broadcast advertisements, we
22 encourage FDA to commission research to determine which
23 formats of supplemental written information are most useful
24 in terms of improving consumers' medicine adherence and
25 health outcomes as determined by a health care

1 professional--their health care professional and improving
2 information exchange between the patient, his or her
3 prescribers, pharmacists, and other health care
4 professionals.

5 The study could concentrate on a prescription drug
6 or class of drugs representing the top drug or drugs used
7 predominantly by women, older adults, or children, and that
8 has been targeted for heavy DTC broadcast or print
9 advertising since the agency published its guidelines in
10 August of '97.

11 Findings from this research can provide guidance
12 to those engaged in developing their own versions of "useful
13 written information." Although the 1997 action plan for the
14 provision of useful prescription drug information recommends
15 specific criteria for the content and format of written
16 information, these recommendations are largely untested.

17 Secondly, FDA is encouraged to support and
18 participate actively in the development of a collaborative
19 national consumer medicine safety and education program, the
20 goals of which would be to educate consumers and providers
21 about changes and improvements in medicine information,
22 promote question asking, and information sharing, as
23 valuable tools to improve communication, knowledge, and
24 usefulness, and to better equip consumers and care-givers to
25 recognize and report medication-related errors.

1 The campaign could be modeled after the
2 Partnership for Food Safety Education, which includes
3 industry, consumer groups, HHS, CDC, USDA, and the
4 Department of Education. The partnership, currently funded
5 by nine industry organizations, is developing, disseminating
6 and evaluating a single food safety slogan and several
7 standard educational messages.

8 The partnership has launched a nationwide food
9 safety education campaign targeting the general public with
10 a focus on key concepts tested for maximum consumer
11 understanding, the Fight Bac--B-a-c--campaign includes a
12 slogan, a logo, and identifiable character.

13 The campaign utilizes multiple information
14 channels, the mass media, public service announcements, the
15 Internet, point-of-purchase materials, and school and
16 community outreach efforts to alert consumers about the
17 problem of foodborne illness and to motivate them to take
18 action.

19 FDA is urged to take the lead among Federal
20 agencies in developing a memorandum of understanding or
21 other such agreement among Federal agencies to organize and
22 support a national consumer medicine safety and education
23 program, which could be modeled after the partnership for
24 food safety education.

25 NCPIE, as an umbrella organization, representing

1 diverse stakeholders, would take responsibility among
2 private sector stakeholders to garner support for the
3 program among groups representing health care providers,
4 consumers, and the pharmaceutical industry, among others.

5 The FDA, consumer organizations, industry groups,
6 and other stakeholders should all participate and/or
7 contribute resources toward message design, testing,
8 implementation and evaluation.

9 Such a consumer education effort was recommended
10 in the action plan for the provision of useful prescription
11 medicine information, which NCPIC helped to develop in 1996.

12 Most recently, in 1997, national pharmacy
13 organizations convened a symposium to develop strategies for
14 overcoming barriers to effective oral counseling about
15 prescription medicines, lack of consumer awareness of the
16 value of medicines properly used, and the potential for harm
17 from medicines used incorrectly.

18 A recommendation from that symposium calls for
19 development of a sustained national consumer education
20 program.

21 Two current Federal educational campaigns, the
22 FDA's Take Time to Care Initiative, which targets
23 under-served women over age 45, and the CDC's Campaign to
24 Reduce Microbial Resistance Through Promotion of More
25 Judicious Antibiotic Use, laid the groundwork for a

1 collaborative national consumer medicine safety and
2 education program targeting the broader public.

3 What is needed next is a collaborative effort to
4 coordinate, broaden, and sustain a broad-based national
5 medicine safety and education program by crafting a
6 universal campaign with messages relevant to all medicine
7 users and care-givers.

8 This will take a commitment from FDA to take the
9 lead in recruiting relevant Federal agencies and some
10 earmarked Federal funds to fulfill its part of the program.

11 In addition to the CDC, FDA is also encouraged to
12 enlist the Agency for Health Care Policy and Research, which
13 recently teamed with NCPPIE to produce and distribute a
14 16-paged booklet, "Prescription Medicines and You," a
15 consumer guide in English, Spanish, and four Asian
16 languages, and the Health Care Financing Administration,
17 HCFA, whose recently launched national Medicare education
18 program, for example, affords yet another opportunity to
19 integrate the dissemination of consumer medicine education
20 messages to Medicare beneficiaries who are most at risk of
21 the consequence of uninformed medication use.

22 NCPPIE is committed to this type of collaborative
23 educational approach and welcomes the responsibility to
24 recruit private sector sponsors and partners, organize
25 planning and strategy development sessions, and manage the

1 program. FDA should assume such responsibilities and see
2 such leadership opportunity in the public sector.

3 We look forward to further discussions about this
4 important opportunity.

5 Thank you very much.

6 DR. NIGHTINGALE: Thank you, Mr. Bullman.

7 Are there any comments or questions from the FDA
8 panel?

9 [No response.]

10 DR. NIGHTINGALE: Thank you.

11 Let's go on to Diane Cousins, who will be
12 representing the United States Pharmacopeia.

13 MS. COUSINS: Thank you, Stu.

14 Good afternoon. My name is Diane Cousins, and I
15 am the vice president for Practitioner Reporting Programs at
16 USP. I speak today representing USP, and as you are
17 probably aware, USP is recognized in the Food, Drug and
18 Cosmetic Act for establishing standards for drugs and
19 related products.

20 USP appreciates the opportunity to present its
21 recommendations on question three which speaks to the
22 post-marketing surveillance system for reporting problems
23 with FDA-regulated products. Today, my remarks are limited
24 to the area of practitioner reporting of adverse events,
25 especially medication errors.

1 For the past 27 years, USP has operated
2 practitioner-based reporting programs known today as the USP
3 practitioners reporting network, or USPPRN. The three
4 programs of the USPPRN collect information about the quality
5 and safe use of prescription and over-the-counter drugs for
6 human and veterinary use, and it has become an integral part
7 of USP's standard-setting activity.

8 As a unique partner in MedWatch, USP shares its
9 reports with FDA to become part of the pool of voluntary
10 practitioner reports upon which FDA has based its
11 post-marketing surveillance efforts.

12 The USP veterinary practitioners reporting program
13 has collaborated with FDA, CVM, and the American Veterinary
14 Medical Association to encourage reporting by raising
15 veterinary practitioner awareness and simplifying the
16 reporting process.

17 The USP medication errors reporting program is
18 another of the USPPRN programs.

19 The submission of these reports to the FDA in the
20 early '90s became the impetus for the FDA's formation of the
21 current Medication Errors Committee within the agency.

22 USP offers three specific recommendations today
23 based on the experience gained through the USP medication
24 errors reporting program, which we believe will help the
25 agency to focus its resources on stimulating adverse event

1 reporting and reducing morbidity and mortality due to
2 medication errors.

3 First, USP encourages FDA's continued involvement
4 in the National Coordinating Council for medication error
5 reporting and prevention in which it is a founding member.

6 This multidisciplinary group of 17 national
7 organizations is coordinating efforts aimed at reporting,
8 understanding, and preventing medication errors in all
9 segments of the medication use process and by all health
10 system participants.

11 The active involvement of FDA has been invaluable
12 in the development of numerous recommendations aimed at the
13 safe use of medications by health professionals and
14 consumers alike.

15 The Council's most recent recommendations aimed at
16 error avoidance in the labeling and packaging of drug
17 products are an excellent example of the agency's
18 interaction with private sector groups of stakeholders and
19 industry standard-setting health professions and health care
20 organizations.

21 Second, USP supports the FDA's exploration of
22 minimizing medical product errors through the systems
23 approach, and as ASHP mentioned earlier, through the human
24 factor science of failure mode and effects analysis, whereby
25 industry would consider the error-prone aspects of its

1 product's design, naming, labeling, and packaging, and
2 present a plan for error avoidance in a preapproval stage as
3 part of the NDA submission.

4 Through this forethought in product development,
5 anticipated errors could be designed out of products, and
6 based on past experience of error situations gained through
7 such programs as the USP medication errors reporting
8 program.

9 Finally and most emphatically, USP recommends that
10 FDA pursue collaborative partnerships and explore
11 utilization of private sector programs that collect adverse
12 drug events from health care practitioners and facilities in
13 order to give the agency the flexibility to focus its
14 resources on the analysis of such data, rather than on the
15 collection of the data.

16 The FDA's encouragement and support of such
17 systems may foster improved reporting because such systems
18 can be anonymous in nature and can help to avoid the
19 negative response likely to occur with any effort to mandate
20 reporting by health professionals or facilities.

21 Further, the causes of preventable adverse drug
22 events are multi-factorial. Therefore, the solutions to the
23 errors are multi-faceted and often outside the regulatory
24 authority of the agency, such as reports of medication
25 errors and the categories of dose omission or wrong-time

1 errors or practice-related issues.

2 USP has just initiated a program called MedMarks,
3 an Internet-accessible program for hospitals to anonymously
4 report, then track and compare their medication errors to
5 other facilities nationwide. The use of MedMarks in
6 hospitals will enable epidemiological analysis through its
7 facility profile feature, which describes the type of
8 hospital, its bed size, its ownership, and the services it
9 offers.

10 Because it is anonymous structured, MedMarks has
11 been praised by recognized experts and leading organizations
12 in the medication safety arena as addressing the number-one
13 perceived obstacle to reporting, and that is liability.

14 Yet, MedMarks has integrated a communication
15 mechanism through the use of hospital PIN numbers to enable
16 confidential communication with the facility and enable
17 further discussion about an event, and on a general basis,
18 to broadcast alerts about hazardous situations, both
19 important features to FDA.

20 The use of a nationally standardized format for
21 data collection, like the National Coordinating Council's
22 medication error definition and its categorization index,
23 are incorporated in MedMarks and help ensure that all errors
24 reported will reflect comparable information.

25 USP encourages FDA's collaboration on this

1 important project. The utility MedMarks can provide to FDA
2 would enable the agency to focus only on those medication
3 errors in which it is specifically interested. If FDA finds
4 that program useful, especially for its presence in
5 hospitals nationwide, the technology could easily support an
6 adverse drug reaction component, for example, through
7 hyperlinks to FDA's database.

8 In closing, let me reemphasize USP's commitment to
9 working with the Food and Drug Administration in any
10 capacity that will improve identification of adverse drug
11 events and the solutions to them, thereby improving patient
12 safety.

13 Thank you.

14 DR. NIGHTINGALE: Thank you, Ms. Cousins.

15 Are there any FDA questions or comments?

16 [No response.]

17 DR. NIGHTINGALE: No? Okay. In that case, we
18 will go to our final presenter, and that is John Isidor
19 representing the Consortium of Independent IRBs.

20 MR. ISIDOR: Thank you, Dr. Nightingale.

21 It is a distinct honor to be the last presenter.
22 There are probably some happy faces out there, knowing that
23 we are wrapping up.

24 I represent an entity known as the Consortium of
25 Independent Review Boards, which presently is a group of 10

1 independent, otherwise known as central institutional review
2 boards, located geographically diverse throughout the United
3 States.

4 The board that I am affiliated with is located in
5 Cincinnati, Ohio. I am a practicing attorney, as well as
6 the chairman of that IRB.

7 There was a previous mention this morning in
8 reference to central IRBs or independent IRBs, and I wanted
9 to in part respond to some of the things that were briefly
10 mentioned.

11 I also wanted to mention that my remarks will be
12 quite brief. I would welcome any comments or questions from
13 the FDA panel.

14 Our organization was created 5 years ago to
15 provide a vehicle for central IRBs to share information
16 regarding investigators, regarding State laws, regarding
17 human subject protection issues that go across the board in
18 terms of what an IRB is designed for, which is primarily to
19 protect the rights and welfare of human subjects.

20 I think the organization has been effective in
21 that regard in providing a conduit and trying to strengthen
22 all of the boards in that mandate, in that mission to
23 protect human subjects.

24 The IRBs that are affiliated with our
25 organization, some are as old as 30 years. One of our

1 members was founded in 1968. Our particular board was
2 founded in late 1983, and so a lot of the members have been
3 around for quite a long time, and our constituency and our
4 membership on our board has been fairly stable.

5 The individuals that are the board members
6 obviously meet the criteria for constituency on an
7 institutional review board.

8 The previous presenter suggested that IRBs were
9 merely allowed to be created by FDA, but I would state that
10 we have reviewed FDA-regulated studies, NIH-regulated
11 studies, and studies that were conducted by investigators
12 outside the jurisdiction of both the FDA and NIH.

13 All of you know who have ever participated or been
14 involved in an institutional review board, in addition to
15 FDA-regulated studies and NIH-regulated studies, there also
16 is much research that is conducted in institutions on human
17 subjects that is not under the jurisdiction of either
18 Federal agency.

19 Our members have undergone over many years
20 multiple FDA audits, inspections, some lasting quite a few
21 days, and the results, I think in large part--and FDA would
22 recognize it--have been similar to the results of
23 institutional review boards located at hospitals and at
24 universities. In some instances, the results have been no
25 deviations found, and others, they have not been quite that

1 good.

2 Also, our membership was recently the subject of
3 something I am sure the FDA panel and most of the audience
4 is aware, was there was an extensive report by the Office of
5 Inspector General that was issued on June 11, 1998. It was
6 subject to much publicity in the Washington Post, the USA
7 Today and some other national publications.

8 That report contained four volumes and was
9 entitled "IRBs, A Time for Reform." Volume three of that
10 report was specifically focused on independent IRBs and
11 central IRBs, such as the members which make up CIRB.

12 The results of that report concluded that the
13 independent IRBs have brought some innovative and beneficial
14 approaches to IRB review, such as the ability to promptly
15 review protocols, amendments, safety information regarding
16 FDA-regulated products, which would enhance the protection
17 of human subjects, and the idea that it was prompt review
18 did not mean it was not thorough review.

19 Additionally, central IRBs oftentimes review
20 products across different phases of FDA drug development,
21 and anyone that knows about some of the products that have
22 recently been withdrawn from the market understand that
23 safety profiles emerge during the course of drug
24 development.

25 Central IRBs being sensitive to safety information

1 from multiple sites and multiple information regarding those
2 products have developed a sensitivity and understanding of
3 that safety information and have developed mechanisms where
4 if new information, as required by Federal regulations,
5 needs to be provided to human subjects, that can be done in
6 a prompt and protective manner. I think that is something
7 that is very worthwhile.

8 My last thing that I am going to address today is
9 an issue that I think was disseminated in the materials in
10 preparation for this meeting. What can FDA do to help the
11 IRB review process? I would agree with Dr. Chodosh's
12 initial comments that some and many IRBs are often
13 overburdened by a variety of things, and the deluge with
14 information that it needs to review and process.

15 I have two suggestions. One, I don't believe FDA
16 currently requires that audit information regarding clinical
17 investigators be provided specifically to reviewing IRBs
18 that are reviewing that clinical investigator that may have
19 been subject to an FDA audit.

20 I think that that should be a requirement that
21 would be very helpful to the IRB, if they can learn
22 information regarding that clinical investigator's previous
23 FDA audit history.

24 Point two, FDA currently does not require IRBs to
25 report either rejections of protocols or modifications of

1 protocols to the agency.

2 Dr. Chodosh pointed out that sometimes it is
3 difficult for an IRB to review a protocol and safety
4 information in isolation, particularly when previous
5 information is availability from very thoroughly and
6 competent IRB review. So I think the recommendation would
7 be, if there is suggested negative viewpoints by a
8 particular IRB, that that information be some way made
9 available to all subsequent IRB review, and that clinical
10 investigators be required to declare that information to any
11 subsequent IRB.

12 Secondly, that if there were modified decisions by
13 the IRB regarding its review of a protocol, that that
14 information be available to subsequent IRB review.

15 I think both of these points could enhance the IRB
16 review process and could add additional protection for human
17 subjects.

18 Thank you very much.

19 DR. NIGHTINGALE: Thank you, Mr. Isidor.

20 Are there any questions or comments from the FDA
21 panel?

22 Susan?

23 DR. ALPERT: I think it would be helpful to
24 clarify what happens in a situation where research is being
25 done in an environment where there is a local IRB, and yet,

1 an independent has reviewed. Is there a mechanism for that
2 interaction?

3 MR. ISIDOR: You mean for the same investigator?

4 DR. ALPERT: If a central IRB has reviewed a
5 protocol for a product and then the research is also going
6 to be done in a location with its own IRB, is that
7 re-reviewed? I mean, that is one of the questions, I think.

8 MR. ISIDOR: Oh. Yes, it is re-reviewed, and
9 presently, there is no mechanism in place to share the
10 central IRB's evaluation of that protocol. That is why I
11 was suggesting that there could be some mechanism created
12 where that local IRB illustration, a small community
13 hospital IRB, may have access to a prior review which would
14 certainly be important for their decision regarding the
15 appropriateness of that protocol in their community.

16 DR. NIGHTINGALE: Any other questions, comments,
17 or thoughts from the panel?

18 [No response.]

19 **Concluding Remarks**

20 DR. NIGHTINGALE: We are actually right on time at
21 this point.

22 I have about 3 minutes worth of closing comments.
23 So, if you will bear with me, I will try to give a very
24 brief summation of some of the themes we have heard today,
25 but before doing that, let me just say that we have heard

1 that the time for getting comments in has been extended from
2 what the Federal Register says, from September 11th to
3 September 21st. You can submit either by regular mail,
4 e-mail, or online to the docket. All the information on how
5 to do it is in your packet where the Federal Register
6 announcement for this meeting states it, but the date says
7 September 11th. So you are given some extra time for that.

8 I would say I will now try to briefly summarize
9 some thoughts.

10 Clearly, the organizations have many good ideas,
11 and they want to help us in what we are doing, and many of
12 these good ideas need to be mined and pursued, and we will
13 be looking at the transcript of this meeting as well as the
14 transcripts of all the stakeholder meetings for this
15 information.

16 Clearly, many want better communication between
17 FDA and the organizations using the Internet, the worldwide
18 web, hot links. The idea of a hot button for FDA
19 information on the home pages of organizations is really
20 something that we heard and want to explore further.

21 The organizations want a transparent process and
22 have more input into what we are doing. There is a concern
23 about product information, especially to have timely and
24 user-friendly information for both health professionals and
25 consumers when a product is marketed.

1 The importance of getting a better handle on or
2 better ways of dealing with adverse event reporting,
3 medication errors, product design issues, improvements in
4 our current systems are needed, especially enhancing
5 MedWatch. These are clearly things to be followed up on.

6 There was general agreement, of course, that FDA
7 should not lower its approval standards, but the expedited
8 approval, approaches to access need to be continued, and
9 some of the organizations have ideas about how to do this,
10 some using advisory committees.

11 There was much support for our tobacco efforts and
12 to continue these.

13 International harmonization was mentioned by a
14 number of the groups as part of the theme. There was don't
15 lower your standards when you are harmonizing, but FDA
16 science base in this is extremely important as well.

17 There was a lot of discussion about professional
18 and public education in general, the idea of FDA working
19 more with other Federal agencies, as well as the
20 organizations, and CDC and HCFA were singled out for
21 particular attention. Of course, the organizations
22 themselves offered to work with us more.

23 A suggestion was made that in fact to have an FDA
24 presentation on every panel, rather at every annual meeting
25 of the organizations to have some kind of an FDA panel or

1 speaker.

2 Areas that need more study in research included
3 some of the pediatric issues, gender issues, as well as
4 adverse event reporting, and how we deal with the ethnic
5 minorities in access issues and clinical trials clearly is
6 an area of concern where more can be done.

7 Problematic areas or questions about issues
8 included some concerns about the IRBs, their being overly
9 stressed in terms of their workloads and their funding. We
10 heard some discussion about different approaches and
11 thoughts about independent IRBs.

12 There was a real urging of FDA to consider more
13 partnership with public and private and non-profit
14 organizations; for example, looking at everything from
15 dealing with the treatment for addictions to patient
16 information, medication errors, et cetera.

17 There is a definite desire to have more feedback
18 from FDA on much of what is occurring, MedWatch reports,
19 analyses of the reports, and we just heard about the
20 importance of making sure that IRBs are fully informed about
21 not only other IRB activities, but also audits of clinical
22 investigators.

23 It was stressed that FDA needs the very best
24 scientific base for its decision-making, and that should be
25 enforced.

C E R T I F I C A T E

I, **THOMAS C. BITSKO**, the Official Court Reporter for Miller Reporting Company, Inc., hereby certify that I recorded the foregoing proceedings; that the proceedings have been reduced to typewriting by me, or under my direction, and that the foregoing transcript is a correct and accurate record of the proceedings to the best of my knowledge, ability and belief.

A handwritten signature in black ink, appearing to read 'T.C. Bitsko', written over a horizontal line.

THOMAS C. BITSKO