TESTIMONY
House Committee on Oversight and Investigations
Wednesday, May 14, 2008
Preemption – Drugs and Medical Devices

My name is Gregory Curfman, and I am the executive editor of the *New England Journal of Medicine*. I am here today along with my colleague, Dr. Stephen Morrissey, the managing editor, to provide testimony from our *Journal*. We will make the case that preemption of common-law tort actions against drug and medical device companies is ill advised and will result in less safe medical products for the American people.

The *New England Journal of Medicine* is nearly 200 years old. Our mission is to publish important advances in medical research, including research on new drugs and medical devices. During my 23 years at the *New England Journal of Medicine*, I and my colleagues have published many articles on new drugs. Some of these drugs have succeeded, but others have failed, in most cases owing to problems with safety.

We have learned over the years that approval of a new drug by the FDA by no means guarantees its safety. It is not uncommon for drugs to be approved by the FDA without long-term studies of their safety. Indeed, FDA approval of a drug is just one milestone along a path to the assessment of long-term safety. It is essential that a drug's safety continue to be carefully monitored during the post-marketing period, because we know that serious safety issues may come to light only after a drug has entered the market. I will give three specific examples that I have encountered in my work at the *New England Journal of Medicine*.

The first is rofecoxib, or Vioxx, a COX-2 inhibitor used to treat arthritis pain, which was approved by the FDA in 1998. In 2000, we published in the *New England Journal of Medicine* a clinical trial called the VIGOR study, which showed that Vioxx effectively relieved pain while causing less gastrointestinal bleeding than traditional nonsteroidal painkillers.

However, something that the *Journal* editors learned later was disturbing. What was not adequately conveyed in that article was the fact that for each episode of serious gastrointestinal bleeding *prevented* by the use of Vioxx, one heart attack, stroke, or other serious cardiovascular problem was *caused* by Vioxx. There was a one-to-one trade-off, but the authors of the article, two of whom were employees of the manufacturer of Vioxx, left most of those data out, and therefore the *Journal*'s readers and the public were not fully informed about this serious problem.

The FDA was provided with the missing data after the article was submitted, but it was not until 2002 that the label for Vioxx was revised to reflect these cardiovascular risks; and it was not until 2004, six years after the drug was approved by the FDA and after millions of people had taken it, that it was finally removed from the market, in part owing to the mounting threat of product-liability litigation.

Example 2 is rosiglitazone, or Avandia, which was approved by the FDA in 1999 for the treatment of type 2 diabetes. It was approved solely on the basis of its ability to lower blood sugar. Whether it would make a difference to patients with diabetes by reducing the risk of cardiovascular disease, the major complication of type 2 diabetes, was unknown, because long-term clinical trials to study cardiovascular end points had not been done.

It came as a surprise when, in 2007, researchers from the Cleveland Clinic reported in the *New England Journal of Medicine* that, on the basis of a meta-analysis of data from multiple studies, Avandia appeared to be associated with an *increased* risk of cardiovascular events, not a decrease. This was a worrisome finding for fragile type 2 diabetics.

Even more surprising, was the revelation that the manufacturer of Avandia had commissioned a similar study in 2005 that showed the same result. To meet legal requirements arising from a lawsuit in New York, the company placed the results of that study on a section of its Web site, but those results were never publicized and never published in a medical journal. Today, nine years after FDA approval, Avandia remains on the market, but in November 2007 a warning about potential cardiovascular risks was added to its label, and its use has declined substantially. Last month the FDA sent a warning letter to the manufacturer for failure to submit reports on a large number of studies on Avandia to the FDA, as required by law.

The third example involves a drug called aprotinin--the brand name is Trasylol--which was approved by the FDA in 1993 and is used to control bleeding in patients undergoing cardiac surgery. In January 2006 a study in the *New England Journal of Medicine* suggested that the use of Trasylol was associated with an increase in heart attack, stroke, kidney failure, and death.

Later in 2006 the FDA held an advisory committee meeting to reexamine the safety of Trasylol. Shortly after the meeting, FDA officials were stunned to learn that the manufacturer had commissioned a similar study, which confirmed the findings in the *New England Journal* article, but had withheld the results from the advisory committee.

Tonight at 5:00 p.m., we will publish on the *New England Journal of Medicine* Web site a large clinical trial that shows definitively that Trasylol, as compared with other drugs used to control bleeding, results in higher mortality in patients undergoing high-risk heart surgery. The editorial accompanying the article states that, after 15 years, in all likelihood this is the end of the story for Trasylol.

What do we learn from these examples?

1. Together, these three drugs have placed millions of Americans and other people around the world at substantial risk. But patients who have been harmed by a drug have had the right to seek legal redress. Preemption would erase that right.

2. Serious adverse drug effects may not become apparent until *after* drugs are granted FDA approval, sometimes *long after* approval.

3. FDA approval by no means guarantees the safety of drugs.

4. The Congress's FDA reform efforts in 2007 made it clear that approval is usually based on short-term efficacy studies, not long-term safety studies.

5. Manufacturers may not immediately make public information indicating safety problems with their drugs.

6. Despite the usually admirable work of the FDA, the agency is hampered by lack of resources in addressing drug safety concerns and may be slow in resolving them.

If drug and medical device companies are shielded against common-law tort actions by preemption, what will be the effect on the safety of our drugs and devices? The answer is intuitively obvious. We recently wrote in an editorial in the *New England Journal of Medicine* that the safety of drugs and devices in our country will almost certainly be diminished. If drug and device companies are immunized against product-liability suits, companies will surely focus less attention on the safety of their products. The possibility of litigation serves as a strong inducement for companies to be especially diligent in scrutinizing their products for safety problems. It is questionable that the purported benefit of making drugs and devices available more quickly should outweigh the possibility of redress when safety flaws are discovered later.

Patients injured by unsafe drugs and devices should not be stripped of their right to seek redress through due process of law. Preemption will undermine the confidence that doctors and patients have in the safety of drugs and devices and will have a chilling effect on the doctor-patient relationship, which has traditionally been built on trust.

Mr. Chairman and members of the Committee, we urge you and your colleagues to pass legislation that will unambiguously eliminate the possibility of preemption of common-law tort actions for drugs and medical devices. Removing this patient right would not only be unjust, but will also result in less safe drugs and medical devices for the American people.

Thank you, Mr. Chairman.