news along the pike

MARCH 2000

CENTER FOR DRUG EVALUATION AND RESEARCH

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# Public Workshops Eye Patient Information, Risk

## *Preliminary Study Examined as Model for Large-Scale Survey*

BY NORMAN OLIVER

Participants in a public workshop concluded FDA should find a way to include consumer input in its upcoming evaluation of the usefulness of written information dispensed with prescription drugs. About 150 representatives from consumer groups, professional societies, trade associations and the industry gathered Feb. 29 and March 1 to provide FDA officials with feedback on a preliminary study conducted last year that may serve as a model for this year's assessment.

The study found that nearly 87 percent of new prescriptions were dispensed with some written information in addition to the label and stickers on the medication container. However, the study concluded that the quality of the information was variable with many areas for improvement.

Participants made a number of wide-ranging recommendations. "A lot of what we are hearing would constitute an expensive undertaking," said Nancy Ostrove, Ph.D., moderator of the workshop. Ostrove, from the Division of Drug Marketing, Advertising and Communications, will spearhead the Agency's efforts on this year's study.

*(Continued on page 12)*

## *Consumer Voice in Risk Management Needs to be Heard*

BY TONY SIMS AND NORMAN OLIVER

Discussions about the safe use of medical products that led to the Institute of Medicine's report, *To Err Is Human*, failed to include "the consumer voice and the voice of patient groups," said Center Director **Janet Woodcock, M.D.** A two-day workshop co-sponsored by the Center and the National Patient Safety Foundation began March 27 and took first steps aimed at informing consumer and patient groups and obtaining their feedback. About 100 persons attended; however, organizers expressed disappointment in the turnout considering the extent of the problem.

The workshop consisted of:

- Background information.
- A panel discussion of personal encounters with using drugs safely.
- A briefing on the current risk management system.
- A video and panel discussion of the health care system's difficulties in using drugs safely and achieving solutions that avoid placing blame.
- Opportunities for open discussion as well as public testimony about personal encounters with medical product safety problems.

*(Continued on page 11)*

# ICH Nears Release of Common Technical Document

BY JUSTINA MOLZON, M.S.PHARM, J.D.

Tokyo—The steering committee of International Conference on Harmonization noted that its expert working groups have made "remarkable progress" on the common technical document. During a four-day meeting that began here Feb. 28, the panel announced that a draft should be ready to release for initial public comment this summer. They also began discussions on global cooperation and other possible roles for ICH.

During the FDA delegation's visit to Tokyo, **Larry Lesko, Ph.D.,** and **Peter Honig, M.D.,** presented talks on two recently issued guidances on clinical pharmacology and biopharmaceutics to the Japanese Ministry of Health and Welfare, the equivalent of FDA.

Dr. Lesko discussed the population pharmacokinetics guidance, and Dr. Honig presented the guidance on the evaluation of metabolism-based drug-drug interactions. **Hank Malinowski, Ph.D.,** served as host. Dr. Malinowski is a Mansfield fellow working with the ministry. He will be finishing his fellowship and returning to CDER this summer.

*(Continued on page 9)*

*GUEST NOTEBOOK*

# Celebrating Women's History Month

**BY LAURA ALVEY**

Imagine being an FDA inspector, having to wear a white hat and gloves to work every day, being mistaken for a prostitute while staying alone in a hotel on official government travel or having to prove your worth to your male supervisor by changing a tire? Such was the case if you were a woman breaking into the all-male bastion of FDA field investigators less than 35 years ago.

These were a few of the informative, enlightening and sometimes amusing stories shared by two of FDA's first women to serve as investigators, **Imogene Tibbetts,** formerly of the New York office, and **Mary-Margaret Richardson,** recently retired from the Kansas City district, St. Louis station. The women were part of an FDA program for Women's History Month entitled, "Female Firsts in the Food and Drug Administration." The March 6 event was sponsored by the Office of Regulatory Affairs' Federal Women's Program, the Equal Employment Opportunity Staff, the FDA History Office and the Office of Women's Health.

The audience, almost entirely women, heard from **Jane Henney, M.D.,** the first woman to serve as FDA commissioner. "Whenever there's a critical mass of women in an organization, there's a shift in tone, behavior and thinking," said Henney, who noted that 53.3 percent of FDA's workforce are women and 60.7 percent of HHS employees are women.

Tibbetts said that she had no model to follow when embarking on her FDA career. It was unheard of in her day for a woman to go to college and begin a profession other than that of teacher, secretary or librarian. It seems hard to believe now, but there was a time when women didn't travel alone and check into hotels by themselves. Tibbetts recollected her very first road trip as an FDA inspector. She made all the necessary travel arrangements; but, upon arriving at her hotel, she was told they had no record of her reservation. The front desk clerk made no attempt to hide the fact that he thought she was a call girl. Only after showing her FDA badge was she admitted, but even after that she still received a phone call hours later from a strange man asking her if she'd like to get together in the bar. Not all of her experiences were quite so frightening, though. She remembers some men not speaking to her at all, but she also remembers learning from some wonderful male mentors and being superbly trained.

Richardson likened herself to that of a novelty after she took her FDA oath of office in 1965. Her supervisor's philosophy was "take 'em out, get 'em dirty and they'll quit." But he didn't know the tenacity of the woman he had just hired. She always felt that the men were watching her to see if she reacted "stereotypically" and that she had to remain on her toes. She remembers being approached by the wife of one of her fellow inspectors at a Christmas party and told to "leave my husband alone." Richardson said there was a general feeling in those initial years that a woman must be a "gold digger" to be in such a male-dominated profession. On the other hand, she added that she had many wonderful times during her career. She went on to become a public affairs specialist and recently retired after nearly 35 years of service.

There were also advantages to being a woman in those early days. Tibbetts remembers that men assumed she was stupid so they spilled their guts to her—an advantage when building a case against a firm. She also remembers getting a shopping cart to haul her tools and equipment. Her male colleagues looked at her as though she was crazy, but it was only a few years later that each of them had one too!

Both women were presented with certificates of appreciation that read: "In recognition of your contributions to the history of the FDA and the essential role women have played in carrying out its mission."

*Laura Alvey is a public affairs specialist in OTCOM.*

news along the pike

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*OMBUDSMAN'S CORNER*

# What's What

**BY JIM MORRISON**

It's been about two years since I made an appeal for CDER staff to be alert to whether the product they were reviewing was really a drug *(Pike,* April 1998).

I haven't been flooded with questions, so I assume that either everything coming into the Center belongs here, which is mostly true, or that folks don't spend a lot of time worrying about intercenter jurisdiction, which is also mostly true.

Since I am an exception to the latter assumption—it's part of my job to worry about intercenter jurisdiction—I have been thinking about ways to simplify how we distinguish between drugs, devices and biologics.

The boundaries between the different product classes, each of which has its own regulatory system, are interesting. Some fascinating products straddle normal boundaries.

Liquids and powders can be devices—for example, liquid bandage preparations and bone cements. Monoclonal antibodies coupled with oncologic agents are drugs. Cultured skin is a device; although, tissue implants are biologics.

In this counterintuitive world, where products may not be what they seem, it helps to have a general, simplified algorithm to follow. I have devised one, but I stress that it is *only intended for internal use by CDER staff.* It is oversimplified, informal and cannot replace, annotate or amplify the formal intercenter agreements. Any inconsistency with the intercenter agreements is unintended.

The algorithm is designed to be an easy way to decide if it is appropriate to ask the CDER intercenter jurisdiction contact—that would be me—to take a closer look. Ultimately, the determination of intercenter product jurisdiction rests with the FDA Ombudsman's office.

This algorithm may generate more questions for me, but the extra effort is worthwhile if we can avoid learning at a pre-NDA meeting that a product is in the wrong center and regulatory system. This happened recently.

Even if a product doesn't fit anywhere in the algorithm, the prudent rule is: when in doubt, ask!

If you want to take a look at the intercenter agreements, they can be found on the FDA Web site at http://www.fda.gov/oc/ombudsman/pj.htm.

*Jim Morrison is the Center's Ombudsman.*

## Informal Product Jurisdiction Guide

**Drugs**

In general, a product is virtually always a drug if it is:

- Synthetically produced.
- Similar to other products that are drugs and easily characterized.
- An antibiotic to treat humans.

**Biologics**

However, the product may be a biologic—and you should consult the intercenter jurisdiction officer—if it or any of its parts is:

- A vaccine.
- An *in vivo* diagnostic.
- An allergen for therapeutic or diagnostic use.
- Derived from human blood.
- Used in blood transfusion or blood banking.
- A blood-cell substitute.
- An immunoglobulin.
- Composed in any part of intact cells or microorganisms.
- A protein, peptide or carbohydrate produced by recombinant cells or transgenic animals, except for antibiotics, hormones and products very similar to approved drugs.
- An animal venom.

**Devices**

Finally, the product may be a device—and you should consult the intercenter jurisdiction officer—if it or any of its parts uses:

- An implanted drug delivery system.
- Computer software or hardware, for example, programs or devices that calculate dosage or activate the drug.
- Device components, such as: inhalers, catheters, probes or bandages.

A product is also likely to be a device if it:

- Is used to irrigate, moisten, lubricate or flush skin or indwelling devices.
- Protects the body from injury, irritation or infection by physically shielding it.
- Does not achieve its primary function by chemical or metabolic action on or in the body.

# 25th Parklawn Classic Set for April 28, Features 2 1/2-Mile Walk, 5-Mile Run

**BY BRONWYN COLLIER**

The silver anniversary of the Parklawn Classic will be on April 28 at 11 a.m. at the Parklawn Building. This year's event will introduce the Surgeon General's Healthy Lifestyles Initiative to the HHS workforce.

The initiative encourages small changes in lifestyles to include regular physical activity and eating a nutritious diet. Participating in the Classic is a perfect way to join the initiative and commit to a healthy lifestyle.

There's something for everyone. For runners, there is a challenging 5-mile course. Those inclined to take their exercise at a more moderate pace can sign up for the 2 1/2-mile walk. The walk is free, and registration for the run is $10 before April 2 and $20 after.

If volunteering to help out with the Classic is more your style, there are many jobs waiting to be filled. To volunteer contact **Laura West** (WESTL, 7-3138).

To register for the run or walk you must be a current or past HHS employee. You can register either by mail or in person at the Parklawn R&W Store in Room 5-01 or, during lunch hours, at tables by the 5-B and 3-B entrances to the Parklawn Building. Registration forms are available on the Classic Web site at http://classic.dhhs.gov or from the Classic Hotline (3-5350, TDD: 4-6990).

*Bronwyn Collier, special assistant in ODE III, is safety marshal for the run.*

*INFORMATION TECHNOLOGY CORNER*

# OIT Presents Electronic Submission Training at DIA Workshop

On March 9, the Office of Information Technology took part in a Drug Information Association sponsored workshop organized to educate pharmaceutical industry professionals on CDER's use of Electronic Submissions.

**Barry Wheeler** and **Tom Selnekovic** from the Division of Data Management and Services presented an outline and guidelines for submissions to the Electronic Document Room. **Tim Mahoney** from the Technology Support Services Staff presented the Center's Electronic Regulatory Submission and Review IT training program that includes customized software classes on electronic review tools.

Feedback from the attendees at both presentations was positive. For more information on the EDR and ERSR training, go to the OIT intranet site at http://oitweb.

### National Records Week

National Records and Information Management Week begins April 2. As part of the festivities, many states and organizations pass proclamations recognizing the important role records management plays in today's complex and fast-paced world.

A two-day seminar starts April 4 for those who work in federal, state or local government records and information. It will be held at the National Archives II building in College Park, Md. The seminar will focus on the new ideas and innovations necessary for the future of records and information management.

For more information on records and information management, contact Scott Zeiss (ZEISSS).

### QA Development Project

OIT is in the process of implementing an extensive project management initiative that will improve the quality of IT service to the Center. Guidance on Creating and Documenting Project Plans has been finalized and is now posted on the project intranet site at http://oitweb/oitActivities/qa_development/.

The next guidances to be reviewed concern project communication and performance tracking. Once these guidances have been approved, OIT will implement the project management practices for all new IT projects. This controlled process will improve OIT's management of IT projects, both large and small, that affect the Center, Agency and our customers in industry and the general public.

The point of contact is **Vali Tschirgi** (TSCHIRGIV).

## April IT Training

| Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|
| **3** | **4** | **5**<br>**Word 97 Intro**<br>9:00-12:00<br><br>**Word 97 Formatting**<br>1:00-4:00 | **6**<br>**Word 97 Tables**<br>9:00-12:00 | **7**<br>**PowerPoint 97 Intro**<br>9:00-12:00<br><br>**PowerPoint 97 Charts**<br>1:00-4:00 |
| **10**<br>**NEST**<br>9:00-12:00<br><br>**DFS**<br>1:00-4:00 | **11**<br>**CDER Standard Letters System 5.0**<br>9:00-11:00 | **12**<br>**NEDAT**<br>9:00-12:00<br><br>**Creating PDF Review Documents**<br>1:00-4:00 | **13** | **14** |
| **17** | **18** | **19** | **20** | **21** |
| **24**<br>**DFS**<br>1:00-4:00 | **25** | **26**<br>**CDER Standard Letters System 5.0**<br>9:00-11:00 | **27** | **28** |

Type http://oitweb in your browser and click on the Training button to access OIT's training resources.

### Help Desk FAQ

**Q: What do I do when the message "McAfee Files are Corrupted" appears during my network login?**

A: When this message appears, your McAfee virus detection software is not updated. To update:

- On the Win 95 taskbar, go to Start | Find | Files or Folders.
- Make sure the Look in: field displays the C:drive.
- In the Named: field, type **dats.**
- Click the Find Now button.
- Delete the **dats** folder found in C:\Program Files\Network Associates.
- Restart your computer. Your anti-virus files will be updated.

### PM Coordination

Currently there are more than 30 projects and potential projects being tracked through OIT's project management coordination effort. OIT senior managers will soon reprioritize a number of on-going projects. When multiple projects compete for resources, assignments will be based on the priority or ranking of the projects. Please visit the OIT web site (http://oitweb) in the coming weeks to view the new project priority list.

The point of contact is **Jayne Ware** (WAREJA).

# Professional Society Bestows Honor on Dr. Temple at Los Angeles Meeting

LOS ANGELES—**Robert Temple, M.D.,** director of the Office of Medical Policy, was named the 2001 recipient of American Society of Clinical Pharmacology and Therapeutics' prestigious Rawls-Palmer Award, one of the society's preeminent scientific awards.

Center Director **Janet Woodcock, M.D.,** presented her talk "Managing the Risks of Drugs: Who is in Charge?" at a plenary session of the society's 100th annual meeting held here in early March.

Dr. Temple discussed the ethical issues of placebo-controlled trials, informed consent and conflict of interest in a public policy forum and engaged Marcia Angell, M.D., editor-in-chief of the *New England Journal of Medicine,* in a spirited question and answer period.

**Peter Honig, M.D.,** OPDRA director, gave a presentation entitled "Challenges in postmarketing risk-benefit decision-making: How can the Centers for Education and Research in Therapeutics help?" Dr. Honig was also named an incoming vice-president of the society.

*—Peter Honig*

*REVIEWER'S CORNER*

# Committee for Advanced Scientific Education Seeks New Members

**BY ROBIN HUFF, PH.D.**

The Committee for Advanced Scientific Education will solicit nominations of new members in April. Nominations are due April 24. The mission of CASE is to promote excellence in advanced scientific education. The committee is composed of approximately 25 members representing the major scientific disciplines within CDER.

One of the most visible activities of the committee is the weekly series of CDER Seminars and Scientific Rounds. The seminar affords reviewers the opportunity to hear from prominent experts in academia and industry, and rounds provides a forum for the Center to discuss difficult regulatory issues that have been encountered during drug reviews.

CASE members have recently undertaken an effort to archive Scientific Rounds on the intranet, so that lessons learned can be referred to in the future when similar regulatory issues arise. Capturing these valuable discussions for future reference is an attempt to move away from relying on oral histories, something Center Director **Janet Woodcock, M.D.,** specifically called for in her 1999 State of the Center Seminar.

In addition to planning seminars and rounds, the committee has recently developed a series of topic-specific lectures, which provide a more in-depth look at a particular topic than is possible in the CDER Seminar. The committee contributes to curriculum development for courses and workshops offered by the Division of Training and Development.

CASE is the body responsible for recommending continuing education credit. This year, the committee has launched efforts to develop a presentation for local hospitals and medical schools that will introduce hospital staff and students to FDA's drug review process.

If you are interested in developing these activities, there will be an e-mail call for nominations issued during the first week of April. Terms of service are three years. Approximately one-third of members rotate each year.

This year, we expect multiple vacancies for chemists, pharmacologists-toxicologists, statisticians and pharmacists. There will be a single vacancy for a clinician. An updated description of the vacancies will be provided in the April e-mail.

Nominations are due April 24 and should include the nominee's *curriculum vitae* and a statement of interest in joining the committee. Self-nominations are acceptable. Nominees will be informed during the first week of June if they have been selected to serve on the committee. New members should plan to attend a local committee go-away on June 28 that provides an orientation to committee activities and goals for the coming year.

*Robin Huf is CASE chair for this academic year.*

*TRAINING AND DEVELOPMENT CORNER*

# CDER's Satellite Education Programs

**BY LINDA EMILIO**

The Division of Training and Development manages CDER's Satellite Education Program, which provides high quality educational opportunities through satellite television broadcasts or videoconferencing. The program expands your choices to help you meet core competencies. Throughout the year, DTD provides programming from many sources, including:

- Alabama Public Health Video Communications.
- CDC's Public Health Training Network.
- Drug Information Association.
- NIH Roundtable Seminar Series.
- PsychLink.
- Public Health Grand Rounds.
- Southern Medical Association.

Programming covers topics of general interest and subjects aimed at specific medical specialties such as oncology or cardiology. Continuing education credits for physicians and pharmacists are available for many of the live broadcasts. Some of the special programming available includes:

- *Healthy People 2010*—HHS.
- "CDER Live!"—CDER and the Drug Information Association.
- "Biological Warfare and Terrorism"—U.S. Army, CDC and FDA.
- "Dietary Supplements Training"—Office of Regulatory Affairs and the Center for Food Safety and Applied Nutrition.
- "Disasters, People, and Public Health"—Public Health Grand Rounds.
- "GERD and its Complications: Focus on Acid Suppression"—MediCom of Princeton.
- Women's health issues
- Electronic records and signatures

Satellite education programs are usually shown in Parklawn 13B-39. The programs can be relayed to other CDER sites via videoconference equipment. In addition, videotapes of satellite programs can be shown at other CDER sites; however, CME and CPE credit can only be earned when you view live broadcasts. Videotapes of satellite broadcasts may be borrowed from the Medical Library in Parklawn 11B-45. Recently, DTD began offering educational videoconferences. These teleconferences are one hour long. A videotape is shown during the first half hour. The second half hour is a videoconference question-and-answer session with the guest speaker.

CDER's Weekly Calendar contains a list of satellite broadcasts including dates, times and locations where they will be shown. Additional information about each satellite program listed in the Weekly Calendar can be found at http://cdernet/dtd/Spring00/Satellite.html. CDER's spring satellite posters and assorted program flyers provide information about upcoming satellite events.

Please contact me by e-mail (EMELIOL) for additional information about satellite education programs, videotape replays and video teleconferences.

*Linda Emelio is an education specialist in DTD.*

# NTEU, Management Seek Reviewers' Opinions on Continuing RAC

Since FDA workers voted to be represented by the National Treasury Employees Union, the question arose whether the Reviewer Affairs Committee may continue in its function to voice the needs and concerns of CDER reviewers to the Center's Senior Management Team. This issue was addressed in October during the last quarterly meeting between the RAC and senior management.

Under the contract, FDA notified the union of standing employer-employee committees that deal with issues affecting conditions of employment for bargaining unit employees. The RAC is such a committee, and now FDA must notify the union whether it wishes to continue the RAC as an employer-employee committee.

If the RAC should continue as such a committee, the union would have the option of either confirming existing bargaining unit participants as the union representatives or appointing new bargaining unit representatives. The union's national office would appoint the bargaining unit representatives.

The RAC accomplishes most of its work through various subcommittees that have been in existence for some time and with members who have experience with the issues. Subcommittee membership is open to all CDER employees. You can find a list of subcommittees and their chairpersons on the RAC intranet site at http://cdernet/rac/index.htm. The subcommittees are continuing work on projects already begun but are not starting any new projects until the issue of the RAC's status is resolved.

Important projects include:

- *Team Model.* This subcommittee held a pilot workshop on best team practices in December and will conduct two more on March 29 and April 17.
- *Guidance Process Improvement and Regulatory Changes Impact.* This group will survey CDER reviewers' awareness of regulatory and guidance changes, whether they have received appropriate training and how they are dealing with these changes.
- *CDER Reviewer Career Path Program.* This subcommittee is planning an evaluation of the senior and master reviewer pilot program.
- *Training and Communication.* This group will be working to improve the RAC intranet site.
- *Comparable Pay.* This subcommittee is working on obtaining the classification needed for clinical pharmacologists and pharmacokineticists to receive pay comparable to industry standards when the budget permits. Other disciplines are also working on the same effort for their colleagues with help from this group.

During October's quarterly meeting, Center Director **Janet Woodcock, M.D.,** expressed her appreciation for the work the RAC has accomplished over the past several years and said that she would like to see the committee continue. The union's representatives have indicated that NTEU supports the RAC's continuation. The union, the RAC and Center management are seeking the opinions of CDER's primary reviewers on continuing the committee.

Dr. Woodcock and RAC Chair **Lydia Kieffer** proposed the organization of a task force to survey Center reviewers regarding the RAC's continuation. The union agreed to allow the survey to be administered. All involved agreed that the survey should be a transparent process and that the issues should be out in the open so that reviewers, the union and management are aware of the various options and their implications. If reviewers' opinions support continuing the RAC, details will have to be worked out so that the committee's existence is in full compliance with the union contract.

Currently RAC membership eligibility and representation encompasses non-management CDER employees and includes bargaining unit members, non-bargaining unit members, visiting scientists and non-management PHS Commissioned Corp officers.

Non-management PHS Commissioned Corp Officers are legally barred from being represented by a union, and visiting scientists are not represented by the union. The RAC is the only mechanism available for individuals in these two groups to voice their opinions regarding CDER reviewer affairs. Under the contract, the union will designate the bargaining unit members to serve on the RAC. These issues present difficult decisions that CDER management, the union and the committee will have to address.

Once CDER reviewers are surveyed and the results analyzed, the RAC will meet with the senior management team and the union to discuss how best to proceed.

Your opinion is very important. If you haven't responded to the March 15 e-mail survey, one is printed on the left.

To return your survey, contact one of the following persons: your RAC representative; RAC Chair Lydia Kieffer (KIEFFERL, 4-2654); RAC Vice Chair **James O'Leary** (OLEARYJ, 4-5756); or RAC Project Manager **Tanya Abbott** (ABBOTTT, 4-6779).

## RAC Continuation Survey

Please respond by close of business April 5. Select one:

☐ The Reviewer Affairs Committee should stay as it is, with all its subcommittees, representing all non-management CDER staffers (both bargaining unit members and nonbargaining unit members, visiting scientists and PHS Commissioned Corp officers) working in conjunction with the union. The union will designate the bargaining unit members to serve on the RAC.

☐ The Reviewer Affairs Committee should be dissolved as an entity along with all its subcommittees.

Comments:

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# Stephanie Gray—Reflections on a Lady, a Leader, a Friend

**BY C. RUSS RUTLEDGE**

**Stephanie Gray** has chosen to retire from FDA as director of CDER's Office of Compliance and take another path in her career. Stephanie's career, detailed in other articles, has moved from consumer affairs officer through office director, with stints as program analyst, compliance officer, director of investigations branch and district director along the way. Rather than rehash these, I thought it would be fun to bring out her non-public side, to explore the persona of this top achiever. We spoke recently about life, dreams, perspective and ambition.

Stephanie has been a friend ever since I first met her almost nine years ago, when she became director of the San Juan District Office. Before that, when she worked there in the late '70s, her daily commute was between Roosevelt Roads Naval Station on the east coast and old-town San Juan. Those of us who have lived in Puerto Rico understand that this 45-mile trip normally takes about two hours by car.

To ease this, Stephanie took flight lessons at the Navy Flying Club, featuring carrier pilot instructors—think "Top Gun"—and earned her pilot's license. She then "fly-muted," weather permitting, between Roosevelt Roads and Isla Grande airports, shaving an hour off each leg of the commute. To hone her piloting skills, she took aerobatics instruction and earned her glider and seaplane ratings as well.

As if flying weren't enough, Stephanie counts golfing, sailing, playing tennis, jogging and dancing as hobbies. Now, she is learning to dance the tango. These are interests that require muscle coordination and strategy to enjoy, as opposed to sitting in the audience. On the other hand, Stephanie loves music—especially jazz—holds season tickets to the opera and enjoys a good book. Like most successful people, she has multiple interests and talents, professionally and personally.

When she was asked which accomplishment as director she was most proud of, she didn't provide an answer about a high-profile project. Instead, she said that she doesn't typically look back at what she's done. Rather, by the time one project is finished, she is already focussed on the next. In general, she said she is proudest of those instances when she has had a positive impact on someone's life. Stephanie has mentored and sponsored people many times.

"No one can do it all by themselves," she said. "People have helped me throughout my career, and I try to help others when the opportunity arises." She is quick to praise and thank others, yet reluctant to enumerate her own accomplishments.

When asked about advice for those interested in furthering their careers, she responded that she thinks in terms of principles—keeping her focus on what is important in life and work. Here are some of her thoughts about career and professional development:

- Consider more than the immediate steps to reach an immediate goal. Think the current situation through to the next logical step and consider where that will lead.
- Help others. Give breaks when possible.
- Read broadly. A person who focuses on the *Federal Register* and his or her own specialty but neglects cultural reading and the news is missing out.
- Seek out educational opportunities and act on them. Learning is a lifelong process. For instance, Stephanie is taking conversational French now, has studied Spanish, and tries to learn a little of the language of each country she visits. Stephanie is able to speak knowledgeably about many topics.

When asked about her satisfaction with her career choices, she said she has a "don't look back" philosophy. Make your best choice with the facts at hand, she said, "and make the most out of the choice you made. There will be other opportunities down the road."

When asked if she would have done anything differently, she replied that while nothing is perfect, she has no regrets.

This reminded me of the "Investment In Excellence" training she brought to San Juan and the Office of Compliance. The program teaches one how to think in terms of what he or she can do, how to define and accomplish goals and how to maintain positive thoughts (the "I can do it" attitude). Stephanie lives this philosophy and is proof of its validity.

I can think of many times she has helped me: advising me how to find detail opportunities when I was seeking to broaden my work experience, how to refocus so that I could turn around tough situations in the workplace and how to find and concentrate on the positive aspects of anything, regardless of how hidden they might seem.

When I thought about the conversation later, it seemed to boil down to cultivating good karma—the good you do will come back to you. This about summed up how Stephanie caught her rocket up through the ranks. She has always treated me fairly and with respect, leant an ear when I needed to confide in someone and offered advice when I needed it.

*C. Russ Rutledge is a compliance officer in the Division of Manufacturing and Product Quality, Office of Compliance.*

***PIKE'S PUZZLER***

## Do You Know Your Adverse Events?

**BY TONY CHITE**

Select the best answer to define these adverse events by matching one number to one letter:

| | |
|---|---|
| 1. nystagmus | a. abnormal hairiness |
| 2. pyuria | b. lockjaw |
| 3. hirsutism | c. weakness; loss of strength or energy |
| 4. bruxism | d. pain in a muscle |
| 5. somnolence | e. presence of pus in the urine |
| 6. trismus | f. abnormal burning (touch) sensation |
| 7. myalgia | g. rapid, rhythmic movement of the eyeball |
| 8. torticollis | h. sleepiness |
| 9. asthenia | i. inflammation of the lips |
| 10. dysgeusia | j. contracted state of cervical muscles |
| 11. paresthesia | k. bad taste in the mouth |
| 12. cheilitis | l. gnashing, grinding, clenching of teeth |

Answers: 1g; 2e; 3a; 4l; 5h; 6b; 7d; 8j; 9c;10k; 11f; 12i.

*Tony Chite is a consumer safety officer in CDER's FOI Staff.*

# *Human Drug CGMP Notes* Gets New Editor, Abandons Paper

**By C. Russ Rutledge**

The popular periodical, *Human Drug CGMP Notes,* has a new project manager—yours truly. I take over from **Paul Motise,** the original editor. (Paul is still with FDA, having found new challenges at ORA's Office of Enforcement). Paul served as editor from the first issue in February 1993 through the September 1999 edition.

*Human Drug CGMP Notes* will continue its quarterly publication schedule. *Notes* is considered a Level 2 guidance document, which means it may clarify existing policy and is releasable upon approval of the contents by the director of the Division of Manufacturing and Product Quality. The current edition is available on the CDER Internet at http://www.fda.gov/cder/dmpq/cgmpnotes.htm.

*Human Drug CGMP Notes,* originated by Paul, was conceived as a means for the division to communicate current good manufacturing practice issues to FDA field investigators. That continues to be its primary function, and occasionally articles reviewing basics are published to educate newer field folks.

While the intended audience is FDA field investigators, *Human Drug CGMP Notes* has become widely read by the pharmaceutical industry. Some of the trade industry publications feature reprints of the current edition.

Initially a printed publication, *Notes* is now offered only in electronic format. Since its inception, *Notes* was posted on the Internet on a "gopher server." So, *Human Drug CGMP Notes* has been on the Internet long before Web browsers became popular.

The *Notes* Internet site offers three different formats: MS Word, HTML and PDF. This allows compatibility with a wide variety of computer platforms and software. Past editions are available on the same site.

In addition to clarifying CGMP policy, other items have shown up in *Human Drug CGMP Notes* over the years. These include a list of subject contacts in the division, an annual index of articles, a Fax-Feedback forum and even crossword puzzles. The Fax-Feedback forum provides a convenient method for field investigators to send in CGMP-related questions. It also was a way for interested persons to subscribe to an electronic version.

With broad acceptance and use of the Internet as a primary information medium, CDER has made guidance documents available on its site. At the same time DMPQ was posting *Human Drug CGMP Notes* to CDER's Web site, it was sending electronic versions to subscribers and mailing paper editions to field offices. Maintenance of the e-mail subscriber lists proved to be resource intensive. As for paper copies, not only is it contrary to the U.S. government's paper reduction efforts, we thought it would be better to axe the distribution than axe a tree (we love happy squirrels, too). Therefore, with this edition DMPQ will be publishing *Human Drug CGMP Notes* exclusively on the Internet site.

If you have questions or would like to suggest a current good manufacturing practices topic, please contact me by email at rutlledgec@cder.fda.gov.

*C. Russ Rutledge is a compliance officer in DMPQ. Thanks to Paul Motise for providing historical perspective.*

***Drugs in the News***

# Troglitazone Withdrawn; Cisapride Marketing to be Halted

FDA on March 21 asked the manufacturer of troglitazone (Rezulin)—a drug used to treat type 2 diabetes mellitus—to remove the product from the market. The drug's manufacturer, Parke-Davis/Warner-Lambert, agreed to FDA's request.

FDA took this action after its review of recent safety data on troglitazone and two similar drugs, rosiglitazone (Avandia) and pioglitazone (Actos), showed that troglitazone is more toxic to the liver than the other two drugs. Data to date show that the newer drugs, both approved in the past year, offer the same benefits as troglitazone without the same risk.

"When considered as a whole, the premarketing clinical data and post-marketing safety data from Rezulin as compared to similar, alternative diabetes drugs indicate that continued use of Rezulin now poses an unacceptable risk to patients," said Center Director **Janet Woodcock, M.D.** "We are now confident that patients have safer alternatives in this important class of diabetes drugs."

Severe liver toxicity had been known to occur with troglitazone since 1997. In consultation with FDA, Parke-Davis had strengthened the drug's labeling several times and had recommended close monitoring of liver function.

In March 1999, FDA's Endocrine and Metabolic Drugs Advisory Committee reviewed the status of troglitazone and its risk of liver toxicity and recommended continued availability of this drug in a select group of patients—patients not well-controlled on other diabetes drugs.

Since then, FDA has continued to actively monitor adverse events associated with troglitazone, as well as rosiglitazone and pioglitazone. After up to nine months of marketing experience with these two newer drugs, it had become clear that the newer drugs have less risk of severe liver toxicity.

Janssen Pharmaceutica Inc., of Titusville, N.J., has announced that it has decided to stop marketing cisapride (Propulsid) in the United States as of July 14. The effective date of the voluntary action is intended to provide adequate time for patients and physicians to make alternative treatment decisions. Cisapride is a prescription drug treatment approved only for severe nighttime heartburn experienced by adult patients with gastroesophageal reflux disease that does not adequately respond to other therapies.

As of Dec. 31, use of cisapride had been associated with 341 reports of heart rhythm abnormalities including 80 reports of deaths. Most of these adverse events occurred in patients taking other medications or suffering from underlying conditions known to increase risk of cardiac arrhythmia associated with cisapride.

*ADMINISTRATIVE MANAGEMENT CORNER*

# Customer Survey Sparks Changes for CDER's Administrators

**BY THE COMMUNICATIONS RESULTS TEAM**

As reported previously, the Administrative Management Team established the first administrative performance goals, which were included as part of the CDER's fiscal year 2000 performance plan. The AMT comprises the Center's management officers and program specialists.

The aim of the goals is to foster advancement in the areas of administrative excellence and customer service among AMT members.

The performance goals are to:

- Improve CDER administrative management resulting in a 90 percent customer satisfaction level (a 20 percent increase over the current level).
- Have 80 percent of the AMT meet the core competencies identified for administrative personnel.
- Educate at least 90 percent of the CDER community on the overall administrative management program.

The first major task for AMT was to conduct a customer survey, and this was done in November 1998. All CDER employees received a survey; and 544 completed it, which is a 32 percent response rate. The results indicated that the overall customer satisfaction rate for CDER was 6.3 on a scale of 1 to 10. In order to meet the customer satisfaction portion of the goal, the AMT will need to increase the satisfaction level to 7.5.

A day-long retreat was held in July to evaluate the survey results and develop an action plan to address the areas in need of improvement. The team focused on the general comments to determine what areas could be improved. Recommendations were directed to the Administrative Management Coordinating Committee for referral to the appropriate CDER group, such as the Senior Management Team, the appropriate AMCC subcommittee or senior management officers.

The major tasks undertaken to address concerns were:

- Holding a budget workshop in September to educate all administrative staff on the budget process.
- Scheduling quarterly meetings for administrative staff to discuss administrative issues.
- Developing core competencies for administrative disciplines.
- Streamlining the travel and personnel processes.

The AMT is optimistic that the changes will result in improved customer satisfaction.

A list of comments, action items and the status of actions will be available on the AMCC intranet site at http://cdernet/amcc/index.htm in the near future. Questions on the administrative program can be sent to this e-mail account: AMT.

*Chairpersons of the AMCC Communications Results Team are Tanya Abbott, OCD, and Becky Nalley, OM.*

# ICH Expects Draft Common Technical Document Release in Summer

*(Continued from page 1)*

The steering committee reviewed plans for November's ICH-5 meeting in San Diego, which will showcase the common technical document, an information package of technical data about a new drug in the same format and with the same content. It could be submitted to drug review authorities in all three ICH regions—the European Union, Japan and the United States.

The expert working groups addressing portions of the common technical document dealing with clinical safety and efficacy (ICH efficacy) and production control and good manufacturing practices (ICH quality) reported that they anticipate reaching consensus at the next ICH meeting in July. The expert working group addressing the sections treating preclinical safety testing (ICH safety) had successfully reached consensus on its draft in October.

The expert panel on electronic standards for the transfer of regulatory information reported significant progress on designing a suitable electronic version of the common technical document. They expect their work on a prototype to be completed about six months after the entire project is finished.

Progress was reported in the following areas:

- Consensus was reached on a draft topic (ICH Step-2) for *Safety Pharmacology Studies (S-7),* which will now be released for public comment in the three regions.
- The group working on the draft topic *Good Manufacturing Practice for Active Pharmaceutical Ingredients (Q7-A)* has almost reached Step 2 consensus.
- Harmonization was achieved for the five general chapters of the pharmacopoeias in the three regions. Further collaborative work on harmonizing with the three pharmacopoeias is anticipated.
- Harmonization of the principles for clinical investigation in anti-hypertensive therapies was completed as part of a pilot project investigating the feasibility of harmonized guidelines in various therapeutic categories.
- The Good MedDRA Coding Working Party has developed a points to consider document on MedDRA term selection. This working document will be widely circulated to users for their input and published on the ICH web site. Information on subscriptions to MedDRA can be found on the Internet at http://www.meddramsso.com.
- The steering committee discussed the possibility taking on harmonization in gene therapy as a topic.
- The ICH Global Cooperation Group, a subcommittee of the ICH Steering Committee, held its second meeting and reported that a priority was enhancing collaboration with the World Health Organization and making comprehensive information on ICH available to non-ICH countries.

The advanced program for the Fifth International Conference on Harmonization, which will take place in San Diego Nov. 9 to 11, has been finalized and will be announced in early April.

*Justina Molzon is the Center's Associate Director for International Affairs.*

# FTC Targets Anti-Competitive Deals Between Generic, Brand Firms

The Federal Trade Commission on March 16 charged a maker of a prescription drug and a generic firm with engaging in anti-competitive practices in violation of the FTC Act. The maker of a widely prescribed drug for treatment of hypertension and angina agreed to pay a manufacturer of generic drugs millions of dollars to delay bringing its competitive product to market, the FTC said.

The Commission also announced in the same release that it had reached a proposed settlement in a second, similar case involving two other drug makers. The settlement resolves charges that the companies entered into an anti-competitive agreement in which a different manufacturer of brand-name drugs paid another generic drug firm substantial sums to delay marketing a generic alternative to its brand-name hypertension and prostate drug.

The financial arrangements between the branded and generic manufacturers were designed to keep generic versions of the two brand-name drugs off the market for an extended period of time, said Richard Parker, head of the FTC's Bureau of Competition. "These types of agreements have the potential to cost consumers hundreds of millions of dollars each year."

He explained that the second case, which involves proposed consents between FTC and the two drug firms, "will provide immediate guidance to the drug industry and the antitrust bar with regard to these kinds of arrangements." He said the first case will allow FTC to consider the issues further as it examines that arrangement in light of a record developed during an administrative hearing.

Under legislation known as the Hatch-Waxman Act, a company can seek FDA approval to market a generic drug before the expiration of a patent relating to the brand-name drug. The law grants the first company to file an ANDA the exclusive right to market the generic drug for 180 days. No other generic can gain FDA approval until this 180-day period expires. The purpose of the exclusivity period is to encourage generic entry.

To begin the FDA approval process, the generic applicant must first certify in its ANDA that the patent in question is invalid or is not infringed by the generic product (known as a "Paragraph IV certification"). Then it must notify the patent holder of the filing of the ANDA.

If the patent holder files an infringement suit against the generic applicant within 45 days of the ANDA notification, FDA approval to market the generic drug is automatically stayed for 30 months, unless, before that time, the patent expires or is judicially determined to be invalid or not infringed. This 30-month automatic stay allows the patent holder time to assert its patent rights in court before a generic competitor is sold.

**First Case Complaint Allegations**

The first case involves the manufacturer of a once-a-day brand-name drug used to treat hypertension and angina. In September 1995, the generic firm filed its ANDA with FDA, and, as the first to file, was entitled to the 180-day exclusivity. The brand-name manufacturer promptly sued the generic firm for patent infringement, which triggered a 30-month stay that expired in July 1998.

In September 1997, the FTC complaint alleges, the brand-name manufacturer and the generic firm entered into an agreement, which paid the generic firm to keep its product off the market.

Under the agreement, the generic firm would not market its product when it received FDA approval, would not give up or transfer its 180-day exclusivity right and would not even market a non-infringing generic version of the drug. In exchange, the brand-name manufacturer paid the generic firm $10 million per quarter, beginning in July 1998, when the generic firm gained FDA approval for its product.

According to the FTC, the agreement acted as a bottleneck that prevented potential competitors from entering the market because the generic firm would not market its product—and thus its 180 days of exclusivity would not begin to run—and other generics were precluded from entering the market because the firm agreed not to give up or transfer its exclusivity.

The complaint alleges that the agreement between the two companies constituted an unreasonable restraint of trade; that the brand-name manufacturer attempted to preserve its monopoly in the relevant market; that both companies conspired to monopolize the relevant market; and that the acts and practices are anti-competitive and constitute unfair methods of competition—all in violation of the FTC Act.

**Allegations in Proposed Consent**

The second case, in which the FTC has reached a proposed settlement, involves a brand-name prescription drug used to treat hypertension and benign prostatic hyperplasia. According to the complaint, the manufacturer of the brand-name drug paid a generic manufacturer $4.5 million per month to keep its generic version off the U.S. market. Because the generic firm was the first filer, other companies were blocked from marketing their generic products. The FTC alleges the brand-name manufacturer determined it would lose $185 million in sales in the first six months of generic competition and agreed to the deal when contacted by the generic firm. The $4.5 million-per-month payments to the generic firm exceeded what it could have earned by actually making the drug.

Under the terms of the proposed settlement, both firms would be barred from entering into agreements in which a first-filing generic company agrees with a manufacturer of a branded drug that the generic company will not give up or transfer its exclusivity or bring a non-infringing drug to market.

**Commissioners Comment**

In a unanimous statement, the five commissioners said: "These consent orders represent the first resolution of an antitrust challenge by the government to a private agreement whereby a brand-name drug company paid the first generic company that sought FDA approval not to enter the market and to retain its 180-day period of market exclusivity."

"Pharmaceutical firms should now be on notice," they added, "that arrangements comparable to those addressed in the present consent orders can raise serious antitrust issues with a potential for serious consumer harm. Accordingly, in the future, the Commission will consider its entire range of remedies in connection with enforcement actions against such arrangements, including possibly seeking disgorgement of illegally obtained profits."

More information is on the FTC Web site at http://www.ftc.gov.

# Workshop Provides Forum for Consumer Voice in Risk Management

*(Continued from page 1)*

- A panel discussion from representatives of consumer groups on how they successfully influenced the system to improve access and safe use of medical products.
- Breakout sessions to discuss a variety of organizational strategies and methods to influence risk management.
- A "town hall" meeting between organizers of the event and participants to discuss partnering issues and future directions.

**Background**

John Urquhart, M.D., a professor of pharmaco-epidemiolgy, outlined key events in drug development—from the first major human vaccinations in 1786 to the discovery of effective AIDS treatments in the 1990s. "Americans struggle with the tangled semantics of the term 'safe,' when applied to medicine," he said. "Safe is a booby-trapped term. The common meaning of safe is 'risk-free.' So nothing is safe. There are only degrees of safety."

According to Dr. Urquhart, prescription drugs are a cornerstone of economic health care; however, their effectiveness relies on reasonably good compliance with the labeled regimen. That compliance is often lacking. One study shows that only 27 percent of patients have control of their blood pressure. Only one in three patients stay on their correct drug regimen. Patients miss doses, fail to take their medicine as directed, or stop taking their medicine completely once they "feel better" despite directions to finish the medicine.

Dr. Urquhart said that the pharmaceutical community needs to embrace the automotive industry's vision of consumer protection. Before 1975, he said, the common view of auto executives was that they could quality control any part of the automobile "except the nut behind the wheel." In the last two decades, however, many innovations in car design aim at protecting drivers from their own mistakes, including seat belts, airbags, computer-controlled electronics and anti-lock braking systems.

The good news, Urquhart said, is that the pharmaceutical industry has embraced the concept of the patient as the customer and is developing ways to track patient dosing histories and possible drug-drug interactions. The bad news, he said, is that the industry is still ignoring information about the effects on patients using drugs at full dose, still struggling to determine what to do when a patient misses a dose and is still unsure about the effects of patients taking a drug holiday, sometimes for weeks at a time.

**Personal Perspectives**

The consumer's struggle to take medicine safely is common to all pill takers, said author Stephen Fried, the first of three speakers to put a human face on risk management. Fried discussed his wife's serious adverse reaction to a single dose of an antibiotic and the couple's subsequent involvement with consumers and risk management issues.

Professor and author Kay Jamison, Ph.D., related her 10-year struggle to comply with lithium therapy for her manic depression. Once her symptoms went away, her desire and incentive to take her medicine went away. Only after recovering from a suicide attempt did she resolve never to stop her lithium.

Judi Herishen, a local CPA, described her saga to maintain health despite an autoimmune disorder and two kidney transplants. Following the second transplant, a new anti-rejection medication caused severe adverse reaction.

**Moving Beyond Blame**

The system of risk management is poorly integrated and outdated; and substantial preventable harm occurs as a result, said Dr. Woodcock. Framing the issue as a "regulatory problem" ignores reality. It's too easy to punish the presumed guilty and not change the fundamentals, she said.

Jim Conway, chief operating officer of the Dana Farber Cancer Institute in Boston, discussed his organization's response to a widely publicized medical error, which claimed the life of a Boston *Globe* medical reporter after a massive overdose of chemotherapy. His organization instituted a patient and family advisory committee that gives patients a say in organizational matters such as reviews of medication errors, treatment protocols and patient education. Conway, who came to Dana Farber from a background in pediatric care, said adult care needs the equivalent of the "mother in your face" who demands to know what is being done to her child and why.

Arnold Gordon, Ph.D., from Pfizer Inc., outlined steps the pharmaceutical industry is taking to eliminate errors and develop solutions. In addition, Dr. Gordon called for an increase in health literacy and numeracy so patients and health care providers can understand directions and take action on regimens.

David Flockhart, M.D., from Georgetown Medical Center, explained the difficulties of conducting research into patient risk and safety. He and other panelists discussed the breakdowns in communication that can occur between patients and their health care providers and among the health care team that takes care of a single patient.

**Influencing the System**

The health care delivery system is relatively new at dealing with risk information, said **Theresa A. Toigo,** R.Ph., MBA, Associate Commissioner for Special Health Issues, who introduced the final panel discussion in which several consumer groups discussed their activities. "Consumers must learn the language of risk," Toigo said. "If not, medical experts will be making decisions that consumers should."

Linda Golodner of the National Consumers League discussed the general principles of involving consumers in public issues. Annette Drummond, from the breast cancer patient support group Arm in Arm, described an outreach effort that generated state government support for a federal mammogram program. Jeff Jacobs, of the AIDS Action Council, discussed how AIDS activism influenced the FDA.

Albert van der Zeijden, of the International Alliance of Patients Organizations, discussed efforts in Europe to develop patient-centered health care. Physicians see patient information as a better way to obtain compliance, he observed. However, patients see information as a way to come to a better judgment about the advice from their physicians. Instead of informed consent, he offered "negotiated consent" as the model for the future. This model attempts to fit the drug regimen into the lifestyle of the patient.

More information about the workshop can be found on CDER's Web site at http://www.fda.gov/cder/calendar/meeting/npsf2000/default.htm.

# Study: Patient Information Accompanies 87% of New Prescriptions

*(Continued from page 1)*

FDA will sort through the recommendations and "clearly go in the direction of consensus," she said. The Agency will do what is in the public health interest in areas lacking consensus and conduct the best study it can within the constraints of resources.

Before any other initiatives can be proposed by FDA, it must first evaluate the success of a public-private action plan that is designed to provide patients with better and easy-to-read written information about their prescription drugs. The plan's goal is for "useful" written information to be given to 75 percent of persons receiving new prescriptions this year. The goal rises to 95 percent by 2006.

A copy of the study report, a transcript of the meeting, other background information and how to comment can be found on FDA's Web site at http://www.fda.gov/cder/calendar/meeting/rx2000.

The workshop included presentations on the background leading up to the study, the study itself, public questions and comments about the study and breakout sessions to solicit suggestions and recommendations for the large-scale study.

**Background**

Thomas J. McGinnis, R.Ph., from FDA's Office of Policy, provided historical background leading to a 1995 proposed rule that would have required the pharmaceutical industry to develop consumer-oriented leaflets, known as "medication guides." The concept of dispensing patient information sheets along with prescription drugs was born in the late 1960s, and it gained support from consumer groups and public health officials through the 1970s. Industry and pharmacists, however, balked at the notion of maintaining an inventory of thousands of consumer leaflets in each corner drugstore across the country.

By the mid-1990s, information technology available in nearly all drugstores precluded the need to store preprinted sheets, and the FDA issued a proposal that set specific goals and time frames for the distribution of patient medication information for private-sector initiatives to meet. A 1996 law preempted a final regulation and, instead, called for voluntary distribution of leaflets through private-sector efforts. Only if the voluntary effort failed could FDA take further action.

The law allowed six months for a private-public collaboration to develop an action plan to achieve goals consistent with those of the proposed rule. It said that useful information must be easily understood, scientifically accurate and nonpromotional in tone and content.

HHS called on the Keystone Center, a public policy and educational organization, to facilitate consensus on the action plan. Judith O'Brien from the Keystone Center summarized her group's consensus building work that involved public meetings and a 34-member steering committee. Committee members represented the pharmaceutical industry, pharmacists, physicians, database companies providing patient drug information and consumer and patient advocacy groups. In January 1997, HHS Secretary **Donna Shalala** accepted the action plan, which outlined the consensus on the components of useful information.

Karen Oster of the National Association of Boards of Pharmacy described her organization's role in contracting for the FDA-funded study and obtaining cooperation from state boards of pharmacy. The boards helped in the random selection of pharmacies and by providing "patient observers" to present prescriptions and obtain any written patient information.

Center Director **Janet Woodcock, M.D.,** discussed the importance of written information in the context of FDA's effort to move the risk management system for drugs forward. She cautioned against underestimating the magnitude of the task. A century or more of a professional model that didn't trust patients with information has created much inertia to be overcome, she said.

**Current Study**

Last year's study assessed the quality of written information voluntarily handed out with prescriptions at a random sampling of about 300 community pharmacies in eight states in the East, Midwest, South West and North West. Principal investigators were Bonnie L. Svarstad, Ph.D., and Dara C. Bultman, Ph.D., R.Ph., of the University of Wisconsin.

Dr. Svarstad noted that "remarkable progress" had been made in the percentage of prescriptions dispensed with written information. "This suggests that the provision of written prescription information is becoming a routine practice in community pharmacies," she said in her report. The 87 percent rate found in the study showed a large increase from the rates found in previous FDA studies using a consumer-recall methodology—16 percent in 1982 and 59 percent in 1994.

The Svarstad study also examined the quality of the information, which hadn't been done in previous studies. A nine-member national expert panel cross-checked the information sheets against a drug-specific evaluation form. The form listed 10 general criteria, based on the action plan's components of useful information, and 28 to 32 sub-criteria tailored to the specific drugs purchased in the study. The drugs—prescription-strength ibuprofen, amoxicillin and paroxetine—were chosen to keep the study affordable and provide patient observers with a reasonable cover story for buying all three at once.

Dr. Svarstad said more than 75 percent of the patient information sheets examined received "high ratings" in such criteria as the drug and its benefits, adverse reactions, an unbiased tone and content, legibility, comprehensibility, scientific accuracy and inclusion of a disclaimer. Improvement was needed in directions, contraindications, precautions, storage, general information, details about the publisher and date of publication. To achieve a high rating, an information sheet needed to meet most of the criteria and sub-criteria.

She noted limitations of the study included granting equal weight to criteria and sub-criteria, self-selection of the states in the study, variability in sampling procedures, limited training of patient-observers and lack of consumers in the evaluation procedures.

Participants held lively discussions in the breakout sessions. Recommendations for consumer input varied from adding consumer representatives to the expert panels to creating separate consumer panels to assess comprehensibility and legibility. Other issues raised were giving some criteria more weight, setting minimum standards or thresholds for usefulness and including mail-order and non-retail pharmacies in the final study.