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3 HEARING ON ``DRUG SAFETY: AN UPDATE FROM THE FOOD AND DRUG

4 ADMINISTRATION''

5 WEDNESDAY, MARCH 10, 2010

6 House of Representatives,

7 Subcommittee on Health

8 Committee on Energy and Commerce

9 Washington, D.C.

10 The Subcommittee met, pursuant to call, at 2:17 p.m., in
11 Room 2123 of the Rayburn House Office Building, Hon. Frank
12 Pallone, Jr. [Chairman of the Subcommittee] presiding.

13 Members present: Representatives Pallone, Dingell,
14 Eshoo, Green, DeGette, Matheson, Barrow, Christensen,
15 Sarbanes, Murphy of Connecticut, Braley, Waxman (ex officio),
16 Whitfield, Shimkus, Buyer, Pitts, Myrick, Murphy of
17 Pennsylvania, Burgess, Blackburn, Gingrey and Barton (ex
18 officio).

19 Staff present: Phil Barnett, Staff Director; Bruce
20 Wolpe, Senior Advisor; Ruth Katz, Chief Public Health
21 Counsel; Sarah Despres, Counsel; Rachel Sher, Counsel; Elana
22 Stair, Policy Advisor; Katie Campbell, Professional Staff
23 Member; Stephen Cha, Professional Staff Member; Virgil
24 Miller, Professional Staff Member; Allison Corr, Special
25 Assistant; Eric Flamm, FDA Detailee; Greg Dotson, Chief
26 Counsel, Energy and Environment; Dave Leviss, Chief Oversight
27 Counsel; Karen Lightfoot, Communications Director, Senior
28 Policy Advisor; Lindsay Vidal, Special Assistant; Mitchell
29 Smiley, Special Assistant; Clay Alspach, Minority Counsel,
30 Health; and Ryan Long, Chief Counsel, Health.

|
31 Mr. {Pallone.} The meeting of the subcommittee is
32 called to order, and today we are having a hearing on ``Drug
33 Safety: An Update from the FDA.''

34 I think before I give my opening statement, I am going
35 to recognize my colleague, the ranking member of the full
36 committee, the gentleman from Texas, Mr. Barton.

37 Mr. {Barton.} Thank you, Chairman Pallone. I just need
38 to make an announcement to the subcommittee. The ranking
39 Republican on the subcommittee is Congressman Nathan Deal of
40 Georgia. As we all know, he announced several weeks ago his
41 intention to resign effective last week. He has since
42 withdrawn the effective date of his resignation until after
43 the vote or votes on the House Floor concerning the
44 comprehensive health care bill. But during that time,
45 Congressman Deal is not planning on attending Congress or at
46 least the subcommittee of which he is the ranking member.
47 Therefore, today I am nominating Congressman Shimkus of
48 Illinois to be the temporary ranking member. That is
49 unofficial obviously because there is no such thing as
50 temporary anything, but he will assume the duties of
51 Congressman Deal until such time as Mr. Deal does effectively
52 resign. When that happens, I will inform Mr. Waxman that it
53 is my intention to make Mr. Shimkus the ranking member of the

54 subcommittee subject to committee approval of such
55 designation. So for today's hearing and any subsequent
56 hearings that this subcommittee has, until Mr. Deal actually
57 resigns, Mr. Shimkus will assume the duties of the ranking
58 member of this subcommittee.

59 Mr. {Pallone.} Well, thank you, and let me congratulate
60 Mr. Shimkus. He has always been very helpful and tried to
61 work in many cases on a bipartisan basis, so I am very happy
62 to welcome him as the new or acting ranking member. I was
63 going to ask, though, the way you described that, Mr. Barton,
64 it sounded like Mr. Deal might still be here for a while,
65 depending on the circumstances.

66 Mr. {Barton.} It is up to you.

67 Mr. {Pallone.} All right. We will have to see. I
68 shouldn't say that actually. He probably won't be here for
69 very long based on what I believe, but we will see. In any
70 case, congratulations.

71 Let me recognize myself for an opening statement. As I
72 mentioned, today the subcommittee is meeting to discuss drug
73 safety. It has been at least a year since our last hearing
74 on this issue and we are here to get an update and overview
75 from the FDA on current challenges and successes with respect
76 to drug safety. Recently there have been a number of drug-
77 related incidents that have shaken public confidence in the

78 FDA's ability to ensure that consumers are using safe and
79 effective drugs. In addition, reports from the Institute of
80 Medicine and the Government Accountability Office highlight
81 the shortcomings of our current system and provide guidance
82 on how to strengthen the drug safety laws to better protect
83 the American public.

84 In response to the incidents, Congress passed the FDA
85 Amendment Acts of 2007, or FDAAA, I guess it is pronounced.
86 This bill was aimed to provide the FDA with additional
87 authorities, specifically post-approval authorities that
88 would help the agency keep drugs safe for consumers to use.
89 For example, the bill provided the FDA with the authority to
90 require drug manufacturers to conduct post-approval studies
91 that would monitor drugs for safety as they are used in the
92 broader population. The bill directed the FDA to establish a
93 post-market surveillance system to improve the agency's
94 ability to detect and act upon drug safety problems and gave
95 the FDA the authority to require drug label changes for
96 safety reasons. It also provided the FDA with the authority
97 to impose Risk Evaluation Mitigation Strategies, or REMS, for
98 drugs and biologics when necessary, and these REMS are
99 designed to manage known or potential serious risks with a
100 drug or biologic to ensure that the benefits of the product
101 outweigh the risks it poses to the patient.

102 Now, the FDA is here today to talk about how effective
103 this law is in protecting the American people from unsafe
104 drugs, and I am particularly curious to hear about the
105 progress on the implementation of some of the post-approval
106 authorities and to learn from the agency of potential
107 stumbling blocks or challenges that will require further
108 Congressional action.

109 Outside of the FDAAA realm, however, we already know
110 that we need to do more to ensure the safety of our drugs.
111 We all remember that horrible incident in early 2008 that
112 again intensified this committee's focus on drug safety.
113 Baxter Health Care Corporation, one of the manufacturers of
114 the blood thinner heparin, which is used to prevent blood
115 clots, began noticing an increase in the number of adverse
116 effects associated with their product. After further
117 investigation, it was determined that the Baxter heparin
118 contained a counterfeit ingredient that mimics an ingredient
119 normally used in heparin production but that is highly toxic
120 and dangerous to humans. Baxter had received this ingredient
121 from a manufacturer in China, and upon further investigation
122 by the FDA, it was determined that due to a processing error
123 at the agency, this Chinese manufacturer had never been
124 inspected by the agency. Tragically, 81 individuals lost
125 their lives as a result of the contamination. Obviously this

126 should not and cannot happen again and we must do everything
127 we can to ensure that it does not happen again. And I am
128 curious to hear the FDA's thoughts and plans for improving
129 import and supply chain safety, especially since the GAO
130 found that roughly 80 percent of the active ingredients used
131 in drugs are actually manufactured abroad.

132 I and a few of my colleagues on the Energy and Commerce
133 Committee introduced a bill this Congress that aims to
134 provide the FDA with additional funding authorities to better
135 regulate the imported materials used in drugs. The bill
136 would also place more responsibility on the manufacturers to
137 ensure that the ingredients they are using are safe. As
138 highlighted by the heparin case, we know the devastation that
139 can come from an unsafe drug supply chain.

140 So I am looking forward to hearing from today's
141 witnesses.

142 [The prepared statement of Mr. Pallone follows:]

143 ***** COMMITTEE INSERT *****

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144 Mr. {Pallone.} I now recognize our new ranking member,
145 my friend, Mr. Shimkus.

146 Mr. {Shimkus.} Thank you, Chairman Pallone. Thank you
147 for your warm welcome. I want to thank Ranking Member Barton
148 for his trust and confidence in me, and I look forward to
149 continuing to work hard on behalf of the committee and really
150 the work we need to do here.

151 The FDA, with all the challenges and the inspection that
152 we do, it is still really the gold standard for health and
153 safety in the world. A lot of countries don't have to do all
154 the research and the testing because we in essence do it for
155 them, so although we will be inquisitive and we will be
156 trying to ask questions, I put that first on the table
157 because they world does rely on what we do here. And we have
158 spent a great deal of time on the issue of drug safety and
159 the Food and Drug Administration Amendments Act, and I look
160 forward to Dr. Sharfstein. Welcome, and I look forward to
161 your updates. And I want to continue to learn more about the
162 Risk Evaluation Mitigation Strategies, known as REMS, how
163 that is progressing and whether information is being
164 disseminated in a user-friendly manner. I am all about risk-
165 based approach. The bills that we passed in a bipartisan, I
166 continuously spoke out on risk-based programs. So I am very

167 interested in that.

168 Your projections for advisory committee members in the
169 future and those projections, I believe it is important to
170 maintain credibility and expert participants. Recent stories
171 indicate the exception reductions provisions may be diluting
172 the advisory committee's ability to serve in those functions,
173 and we do want highly qualified and the best people to be
174 helpful.

175 But in general we know gaps remain when it comes to
176 ensuring the safety of drugs in the United States and I
177 remain committed to addressing those needs along with
178 Chairman Pallone. One thing I know about my colleagues on
179 the other side, they are tenacious in moving in that
180 direction and we want to be helpful in that manner. The FDA
181 continues to make progress in utilizing risk-based systems
182 like PREDICT and I am curious how this might translate in
183 regard to targeting facility inspections. Regardless of the
184 end result, we know that the FDA needs proper funding. We
185 need to identify where we can cut out wasteful spending and
186 make sure funding to ensure the safety of food and drugs in
187 this country does not take a backseat with our appropriators.

188 Lastly, echoing remarks I made in the past, I hope we
189 can work towards these goals using a prudent formula to get a
190 good bipartisan product. Chairman Waxman, Chairman Emeritus

191 Dingell, Chairman Pallone and Chairman Stupak working along
192 with Ranking Member Barton, Deal and myself came up with the
193 food safety bill that ultimately passed the House really in a
194 huge bipartisan manner, and I think we can do that if we move
195 forward in that direction.

196 I look forward to continuing our work to get legislation
197 signed into law and hope we can use the successes of food
198 safety as our motto in any drug safety-related legislation.

199 Thank you, Mr. Chairman. I yield back my time.

200 [The prepared statement of Mr. Shimkus follows:]

201 ***** COMMITTEE INSERT *****

|
202 Mr. {Pallone.} Thank you, Mr. Shimkus.

203 Next is our full committee chair, Chairman Waxman.

204 The {Chairman.} Thank you very much, Chairman Pallone,
205 for holding this hearing today and giving us the opportunity
206 to hear from the FDA on the critically important issue of
207 drug safety.

208 It has been some time since we focused on drug safety,
209 but we did indicate that we wanted to take up this bill after
210 food safety, which was the first step, and now we are going
211 to turn to drugs, medical devices and cosmetic safety issues.

212 We can't forget the lessons of the 2007 heparin
213 contamination catastrophe which resulted in numerous severe
214 allergic reactions and the deaths of at least 80 Americans.
215 In that case, the active ingredient was manufactured in
216 China. Thanks to the excellent work of the Subcommittee on
217 Oversight and Investigations in 2008, we know that this is
218 not a unique situation: the U.S. drug supply is increasingly
219 sourced from abroad.

220 In order to market a drug in the United States, FDA must
221 ensure that the drug meets our appropriately high safety
222 standards. So when ingredients or finished drug products are
223 manufactured abroad, FDA needs to expand its reach if the
224 agency is to meet its responsibilities.

225 As heparin illustrated, FDA clearly needs more
226 authorities and more resources to do a better job policing
227 the safety of imported products. But what heparin also
228 demonstrated is that we cannot expect FDA alone to do this
229 job. We need to place a greater onus on all manufacturers to
230 oversee the safety of their own products. This principle is
231 reflected in the work that Mr. Dingell, Mr. Pallone and Mr.
232 Stupak did on their Food and Drug Administration
233 Globalization Act. For instance, the bill would require drug
234 manufacturers to implement Quality Risk Management Plans to
235 incorporate risk identification and control into their
236 production processes. We need that.

237 This is a principle that should be familiar to all of
238 us. The Food Safety Enhancement Act reflects this kind of
239 approach with respect to food manufacturers. So I am
240 confident we can get the same kind of bipartisan agreement to
241 incorporate this concept into a bill on drug safety as well.

242 I hope FDA will tell us today about what the agency
243 believes it needs to protect us from another heparin
244 disaster.

245 I am also eager to hear about FDA's implementation of
246 the 2007 FDA Amendments Act. Congress made some major
247 strides toward improving the safety of our drug supply in
248 enacting this legislation. For the first time, FDA was given

249 the authority to require manufacturers, among other things,
250 to conduct post-market studies, implement Risk Evaluation and
251 Mitigation Strategies, or REMS, and make safety-related drug
252 labeling changes. This hearing will be a great opportunity
253 to learn about FDA's challenges and successes with the use of
254 these authorities 3 years after the enactment of this
255 landmark legislation.

256 I want to thank Dr. Sharfstein for being here. He is no
257 stranger to me. We worked together in the past today in the
258 Oversight and Government Reform Committee and on many of
259 these very same issues, and I am quite pleased that you are
260 here and feel a sense of confidence that you are responding
261 to us on these issues because I know you share our concern
262 about them.

263 Thank you very much, Mr. Chairman.

264 [The prepared statement of Mr. Waxman follows:]

265 ***** COMMITTEE INSERT *****

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266 Mr. {Pallone.} Thank you, Chairman Waxman.

267 Next is our ranking member, Mr. Barton.

268 Mr. {Barton.} Thank you, Chairman Pallone. We
269 appreciate this hearing today. We appreciate our witness
270 from the FDA coming.

271 Before I give my brief statement on the merits of the
272 issue, I do want to reiterate the importance I place on this
273 subcommittee and the importance I place on Mr. Shimkus
274 assuming the ranking membership. On the Republican side, we
275 have a bidding system for subcommittees where each member
276 gets to rank one, two, three their preference for
277 subcommittees. The most sought-after subcommittee on the
278 Republican side of the full committee is the Health
279 Subcommittee, as it should be, given the size of the health
280 issue in our debates here in the Congress. Congressman Deal
281 has done an outstanding job, first as subcommittee chairman
282 and the last two terms as ranking member but he is pursuing
283 the governorship in Georgia, so I thought long and hard about
284 who to replace him with, and Mr. Shimkus is somebody who has
285 paid his dues. He has an almost 100 percent attendance
286 record as a member of this subcommittee. He also serves on
287 two other subcommittees and his attendance record there is
288 excellent. He gets into the details of the issues, and while

289 any member of the subcommittee on the Republican side I think
290 would make an excellent ranking member, I feel Mr. Shimkus
291 will not have a learning curve, so I welcome him to his new
292 duties and I hope that he conveys to them the same sense of
293 excellence he has in all the other duties he has assumed on
294 the committee.

295 With regard to today's hearing, it is good to review
296 what we have done with the bill that we passed in the last
297 Congress. We are especially interested on the minority side,
298 as has already been outlined, the REMS issue, the Risk
299 Evaluation Mitigation, how that is working. We also would be
300 interested in hearing about the new rules that we put into
301 statute regarding conflict of interest and how those rules
302 are being used. We hear some concern that it has become
303 difficult to get the experts needed on these review panels
304 because of the conflict-of-interest rules that we have
305 adopted, so we want to hear about that.

306 As Chairman Waxman has pointed out, there is hope that
307 we can work in a bipartisan fashion on future FDA reform
308 measures. Chairman Dingell and I are working on that very
309 issue at the staff level, and we are hopeful that our friends
310 on the majority side will adopt the model of bipartisanship
311 that they exhibited in the last Congress and in this Congress
312 so far with the FDA and not the model of partisanship that

313 they adopted on the larger comprehensive health reform bill.
314 I think the proof is in the pudding. When we work together
315 in a bipartisan fashion, we certainly have differences but we
316 end up with bills that pass committee with almost unanimous
317 support and bills that pass the floor with over 400 votes.
318 When the other route is chosen, we have bills that barely
319 pass committee and barely pass the Floor and as of now there
320 doesn't appear to be a compromise between the House and the
321 Senate and the President that can pass anywhere.

322 So we look forward to your testimony, and again,
323 Chairman Pallone and Chairman Waxman, thank you for this
324 hearing.

325 [The prepared statement of Mr. Barton follows:]

326 ***** COMMITTEE INSERT *****

|
327 Mr. {Pallone.} Thank you, Mr. Barton.

328 Next is the chairman emeritus, and I should say that Mr.
329 Dingell, as many of you know, has had a long history of
330 working on this legislation or the issue of drug safety and
331 food safety and is the prime sponsor of the bill that we have
332 been operating on for the last couple of sessions on the
333 topic. Thank you, Mr. Chairman.

334 Mr. {Dingell.} Thank you, Mr. Chairman, for those kind
335 words and I wish to commend you for having this hearing. It
336 is a very valuable event and it will provide us an
337 opportunity not only to receive and update information on
338 drug safety activities at the Food and Drug Administration
339 but also to remind the American people of the hazards which
340 exist with regard to unsafe food and drugs and the fact that
341 this Congress needs to move forward with legislation to
342 address problems in both of these areas.

343 As you know, Mr. Chairman, we have reported from this
344 committee a food safety bill which has passed the House. It
345 came unanimously out of this committee and it has passed the
346 House by an overwhelming vote. It sits, of course, safely
347 ensconced in the United States Senate as these things usually
348 do. We are hopeful that this hearing might trigger some
349 interest in the Senate in this matter so that they can

350 commence to go forward.

351 I want to commend my friend Mr. Barton for his comments
352 with regard to food safety and safety of pharmaceuticals. As
353 you know, Mr. Chairman, you, Mr. Stupak and I and Ms. Sutton
354 and Ms. DeGette sponsor H.R. 759, which is a very significant
355 improvement in all the things at Food and Drug including
356 their authorities to address drug problems, food problems and
357 also importation problems that deal with the importation at
358 the point of import and to see to it that inspections at home
359 and abroad and as well as that that good manufacturing
360 practices obtained abroad, and I want to observe that Mr.
361 Barton worked very well with us on that and that my
362 Republican colleagues and my Democratic colleagues and I will
363 work well to get that bill out of here and through the House.

364 I am hopeful that we can do something similar on the
365 remnants of the legislation which we have passed which was
366 H.R. 759. We received technical comments from the Food and
367 Drug Administration and we believe that those are very
368 helpful and will be incorporated. As my colleague Mr. Barton
369 has observed, his staff and mine are working to see to it
370 that we can bring together a bill which can achieve the
371 support of my colleagues on the committee, and I look forward
372 to the enthusiastic support in this subcommittee and in the
373 full committee, and of course, I look forward to the help of

374 Food and Drug and the Department of HHS as well as the
375 Administration.

376 According to a 2004 HHS report, the Nation's medicine
377 cabinets are still stuffed with enormous amounts of
378 pharmaceuticals. Almost half of all people in this country
379 take at least one prescription medicine and one in six has
380 three or more medications that they take. Americans have
381 come to expect that their prescription drugs will improve
382 health and prolong life expectancy. They do not expect their
383 drugs to cause harm or death. The Food and Drug
384 Administration plays a critical role in ensuring the Nation's
385 drug supply meets the safety expectations of American
386 consumers. The role FDA plays is so critical that it has
387 earned that agency an American Food and Pharmaceutical
388 Products as the gold standard not only of regulatory bodies
389 but as regulatory substances.

390 Unfortunately, FDA approval of pharmaceuticals as a gold
391 standard is now called into question by an unfortunate series
392 of facts. Drug safety incidents have occurred and have
393 created a confidence crisis in FDA. During the past 8 years,
394 Food and Drug was led by leadership specialized at best in
395 gross incompetence or at worst severe deception, and as a
396 result, American lives have been placed in jeopardy under all
397 the products that are marketed under the regulation of that

398 agency, and of course, the confidence of the American people
399 in that agency has been severely compromised.

400 Now under a new Administration, Food and Drug has been
401 taking steps to rebuild, and through Congressional and
402 administrative action, the agency has gained additional
403 resources, not sufficient but to begin enabling it to move
404 towards doing its job properly though many including myself
405 still believe that the resources and authorities of Food and
406 Drug are still lacking in the wake of years of inattention
407 and starvation.

408 In 2007, the Congress made substantial progress in the
409 way of drug safety with the passage of FDA Amendments Act of
410 2007. This law strengthened FDA's post-market safety
411 oversight. No longer is it okay for the oversight to end at
412 the mere approval of a drug. This is a significant step
413 forward. However, it did not take long before we were aware
414 of enormous gaps in FDA's ability to protect consumers from
415 an increasingly global drug supply. In 2008, in one instance
416 alone, 81 deaths of Americans were linked to recalled heparin
417 that contained Chinese tainted API. The safety of imported
418 pharmaceuticals and supplies as well as the raw materials
419 from which these are made is a matter of safety and great
420 concern that must be addressed in this Congress. Last year
421 the Congress unanimously passed the bipartisan bill I

422 mentioned with regard to our food safety supply. I believe
423 that we can and should and will pass similar legislation
424 during this Congress.

425 I look forward to the deputy commissioner's testimony.
426 I hope he is able to give us better testimony than the
427 predecessor of the current head of FDA gave us when he came
428 up to tell us that all was well and to leave a patch of skin
429 behind in this committee because of the unfortunate character
430 of his testimony and his lack of information.

431 Mr. Chairman, I thank you again and I yield the balance
432 of my time.

433 [The prepared statement of Mr. Dingell follows:]

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435 Mr. {Pallone.} Thank you, Chairman Dingell.

436 The gentleman from Indiana, Mr. Buyer.

437 Mr. {Buyer.} Thank you very much.

438 For the past several years, I have been studying the
439 problem of counterfeit drugs entering our Nation through our
440 12 international mail facilities and express carrier
441 facilities. In 2008, Congress Matheson and I introduced the
442 Safeguarding America's Pharmaceuticals Act to combat the flow
443 of unapproved drugs into our country and to strengthen and
444 safeguard the domestic pharmaceutical supply by creating also
445 this system of electronic pedigree. At the beginning of last
446 year when we introduced the legislation, we then submitted to
447 the FDA and other stakeholders, Customers Border Protection
448 and the California Board of Pharmacy to improve the
449 Safeguarding America's Pharmaceuticals Act. I would ask you
450 to look over your left shoulder because there are two ladies
451 that were a lot of help. They put in a lot of time for the
452 technical assistant. Elisa Bernstein, thank you very much.
453 We traveled to many of these facilities with you. And
454 Jeannie Ireland, thank you very much for the technical
455 assistance you have given to make this legislation even
456 better. Mr. Matheson and I have the commitment of Mr.
457 Dingell and we want to make sure that this legislation

458 becomes a reality.

459 Last June, Dr. Hamburg testified before this
460 subcommittee and stated that the problem of counterfeit drugs
461 is a significant concern and gave her commitment to working
462 with me to address the issue, so I turn ask for the very same
463 commitment.

464 The FDA then followed up in its response to many
465 questions for the record and confirmed that the agency
466 supports a single national uniform standard for a drug track
467 and trade system. Additionally, the agency addressed an
468 issue of great importance to me when it stated that it
469 supports streamlining the destruction of these unapproved FDA
470 drugs that constantly come into the market. And let us stop
471 enabling these counterfeiters by this policy of return to
472 sender. It is just awful, and I hope that you can address
473 that to us. The worldwide counterfeit drug market is
474 expected to grow to \$75 billion, so we have to aggressively
475 address this, and I look forward to working with Mr. Dingell
476 to do that.

477 So I know this is a great concern to you, and I look
478 forward to working with you and your comments. I yield back.

479 [The prepared statement of Mr. Buyer follows:]

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481 Mr. {Pallone.} Thank you, Mr. Buyer.

482 Next is the gentlewoman from the Virgin Islands, Mrs.

483 Christensen.

484 Mrs. {Christensen.} Thank you, Mr. Chairman. I am

485 waiving my opening statement.

486 [The prepared statement of Mrs. Christensen follows:]

487 ***** COMMITTEE INSERT *****

|
488 Mr. {Pallone.} Thank you.

489 The gentleman from Georgia, Mr. Gingrey.

490 Dr. {Gingrey.} Mr. Chairman, before I start, let me
491 join with my ranking member on congratulating Mr. Shimkus as
492 ranking member of this Health Subcommittee.

493 Mr. Chairman, first I would like to thank you for
494 calling this hearing today. Ensuring that medications are
495 both safe and effective for our Nation's patients is a goal
496 that I believe we can all support. Whether our inquiries
497 include pre-market and post-market testing of products,
498 domestic and foreign facility inspections or even the
499 authority and resources of the FDA, this committee and its
500 chairman should be commended for their efforts today.

501 However, I want to focus for a moment on some troubling
502 news that just came out of Britain. As some of you may have
503 read earlier this week, the U.K.'s National Health Service
504 received four independent audits on the overall state of
505 their health care system. All four reports found a system
506 that put the politics of the government above the health of
507 the patient. One report based on the evidence of almost 200
508 top managers and doctors in the British system found that
509 hospitals ignored basic hygiene so they could cram patients
510 into beds to meet waiting time targets, thereby losing sight

511 of fundamental hygiene requirements for infection prevention.
512 This neglect of the most basic hygienic standards was
513 credited with causing the deaths of 265 patients in 2005.
514 All four reports in fact hit the same note: the British
515 system placed little emphasis on patient care. Even more
516 shocking, these reports are suppressed by the British
517 government and only came to light recently. To quote the
518 Times of London, ``These reports diagnose a blind pursuit of
519 political and managerial targets as the root cause of a
520 string of hospital scandals that have cost thousands of
521 lives.''

522 I see the same blind pursuit of political targets in our
523 current health care reform debate. For the past week, I have
524 seen the demonization of the insurance industry. Sure, the
525 industry needs reform. We all agree with that. But
526 insurance reforms alone should not be the reason for turning
527 health care over to our government lock, stock and barrel,
528 and if the Senate bill passes, what then? Who is going to
529 monitor our government when it controls all health care
530 decisions? If the British are our example, will politics
531 supersede the needs of patients here like they did in the
532 U.K.? I fear that Washington politics have already trumped
533 their needs. Our constituents are telling us that they want
534 reform but not this reform. They don't want a bill bought

535 with political payoffs and backroom deals. Every day they
536 echo these sentiments, yet their elected officials ignore
537 them. They voted for a Republican to represent Massachusetts
538 in the United States Senate and still Washington refuses to
539 listen. If we cannot trust our government to put its
540 citizens first when debating a health care reform bill, how
541 can we expect it to safeguard their citizens' interests when
542 it controls health care? If Britain continues to be our
543 example, I fear for the safety of patients if our government
544 controls our health care choices.

545 Mr. Chairman, with that I yield back.

546 [The prepared statement of Dr. Gingrey follows:]

547 ***** COMMITTEE INSERT *****

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548 Mr. {Pallone.} Thank you.

549 Next is the gentleman from Iowa, Mr. Braley.

550 Mr. {Braley.} Thank you, Mr. Chairman. I am very
551 pleased that we are holding this important hearing and I am
552 very pleased with the scope of the testimony that Dr.
553 Sharfstein has laid out in his written materials.

554 I want to begin my brief remarks by echoing the concern
555 raised by my colleague from Indiana, Mr. Buyer, because one
556 of the things that was very obvious to me when I visited the
557 Custom and Border Patrol inspection facilities in Nogales,
558 Arizona, and Mexico, is that we have an enormous problem with
559 counterfeit drugs entering through ports of access and other
560 places that are not being controlled, which contributes
561 enormously to the problem you have identified with the known
562 points of products for non-counterfeit drugs. So we have got
563 two major problems in terms of enforceability of the FDA's
564 mandate in counterfeit and non-counterfeit production
565 facilities overseas. We also have enormous challenges in
566 terms of the accountability of the manufacturers of those
567 non-counterfeit and counterfeit drugs in this country, and
568 one of the things that I hope you are able to address in your
569 testimony is what the FDA is doing to promote greater
570 accountability with those overseas manufacturers.

571 I also want to compliment you on some of the progress
572 has been made since the passage of the FDAAA because I
573 personally benefited from one of the changes you identified
574 in your statement where you describe the changes to the
575 prescription information of a class of antibiotics to warn
576 about the risk of tendon rupture. I have experienced a
577 ruptured Achilles tendon, and when I was prescribed those
578 antibiotics, as a patient I was given informed information to
579 make a choice about whether or not to take that antibiotic in
580 light of my own health history. So I can tell you that if
581 consumers are presented with information that allows them to
582 make the choices that are best for them based upon their own
583 unique health conditions, the FDA is fulfilling the mandate
584 that you set forth so succinctly at the beginning of your
585 written remarks.

586 But I also want to hear from you in your testimony about
587 the Sentinel Initiative that you described, which you have
588 identified as a national integrated electronic system for
589 monitoring medical product safety. The concern I want you to
590 address is exactly what model that Sentinel Initiative is
591 based upon because I am familiar with other sentinel event
592 reporting systems that have been adapted in this country
593 designed to promote patient safety that have been woefully
594 inadequate in reaching the level of reporting that would be

595 required to truly bring about changes in patient safety.

596 So I look forward to your comments. I appreciate your
597 willingness to come here today. It is a very important
598 subject that affects every American, and this is not a
599 partisan issue, it is a bipartisan issue that every American
600 should be concerned about, and I yield back.

601 [The prepared statement of Mr. Braley follows:]

602 ***** COMMITTEE INSERT *****

|
603 Mr. {Pallone.} Thank you, Mr. Braley.

604 The gentlewoman from Tennessee, Mrs. Blackburn.

605 Mrs. {Blackburn.} Thank you, Mr. Chairman.

606 I am so pleased that we are doing an oversight hearing
607 today. Oversight is something that we should doing a little
608 bit more of, and I think that after we passed the FDA
609 Amendments Act in 2007 that was supposed to help streamline
610 some of those processes and procedures that it is important
611 that we come back and look at what is happening with the
612 efficiencies in this area as well as to look at the
613 relationship between the FDA and industry, and some of my
614 colleagues have mentioned some of the conflict-of-interest
615 questions that we will have.

616 I also hope that today we are going to look at whether
617 or not the FDA has the appropriate resources as well as the
618 institutional will to continue to evolve and review processes
619 that are in place, and I know, Dr. Sharfstein, that you are
620 very well aware that with the inspections process with NDA
621 and ANDA, we hear from constituents who may have questions or
622 concerns as they have gone through that process. So I think
623 that is something we need to jointly look at to see is this
624 review process working and how do we simplify it, how do we
625 look at time, money, the usage as well as public safety. So

626 I thank you for your willingness to look at that.

627 The other point that I hope we look to is FDA's internal
628 problems and see if those have improved not only with the
629 decision-making process but also the oversight and the post-
630 market drug safety issues that are out there, the
631 counterfeit, and then let us also touch on one of the things
632 we have talked about repeatedly over the last few years which
633 is your interagency communications and the different
634 divisions and how they are transferring that information.
635 Repeatedly we have seen this as a roadblock or being cited as
636 well we didn't know they were doing. So I hope that you will
637 take a moment to address that.

638 I thank you for being here with us. We welcome you.

639 Mr. Chairman, I yield back.

640 [The prepared statement of Mrs. Blackburn follows:]

641 ***** COMMITTEE INSERT *****

|
642 Mr. {Pallone.} Thank you, Mrs. Blackburn.

643 And next, the gentlewoman from California, Ms. Eshoo.

644 Ms. {Eshoo.} Thank you, Mr. Chairman. This is an
645 important hearing, and I thank you for having it.

646 Before the FDA was created about a century ago, taking
647 drugs was a real gamble. There were elixir potions that were
648 sold door to door and ``medicines'' were really taken at
649 one's own risk. Today, as was stated previously and we all
650 know, there are millions of Americans that take drugs to
651 prevent, to treat and to cure ailments from the common cold
652 to cancer, and the science and technology progresses and I
653 see every day the new things that surface in my Congressional
654 district and certainly around the country, so do the
655 complexity of drugs as well as our ability to regulate them
656 and ensure their safety. So I think that the FDA is the gold
657 standard in the world and I think that we all want the FDA to
658 remain the gold standard in the world. The recent heparin
659 incident was a stark example of what happens when that
660 standard is not followed and it cost 81 American lives.
661 Lapses in drug safety not only harm patients but they cause
662 the public, and I think this is really an important outcome
663 of this, it causes the public to doubt the government's
664 ability to actually ensure safety. So we have to maintain

665 the trust and the support of the American people who rely on
666 safe and effective drugs.

667 I am very pleased to see Dr. Sharfstein here today. I
668 would like to know about how the FDA is implementing two
669 provisions that I offered in the Food and Drug Administration
670 Amendments Act to renew and improve the Best Pharmaceuticals
671 for Children Act, the BPCA, and the Pediatric Research Equity
672 Act, PREA. The provisions, as you know, were designed to
673 improve drug safety for children in two ways. First, under
674 the BPCA, the legislation provided an incentive for a drug of
675 the innovator company agrees to undertake comprehensive
676 pediatric studies requested by the FDA, and second, under
677 PREA, the FDA was granted the authority to require studies
678 when there is a demonstrated need and the drug companies are
679 required to submit a pediatric assessment. I am telling you
680 what you already know.

681 So my thanks to Dr. Sharfstein for being here today. I
682 look forward to your testimony. I want to thank everyone
683 that is part of helping to keep FDA as the gold standard in
684 the world and to work with you and make sure that we provide
685 the resource that you need in order to do that and good
686 public policy to back it up.

687 Thank you, Mr. Chairman.

688 [The prepared statement of Ms. Eshoo follows:]

689 ***** COMMITTEE INSERT *****

|

690 Mr. {Pallone.} Thank you

691 Next is the gentleman from Pennsylvania, Mr. Pitts.

692 Mr. {Pitts.} I will waive.

693 [The prepared statement of Mr. Pitts follows:]

694 ***** COMMITTEE INSERT *****

|

695 Mr. {Pallone.} Thank you.

696 The gentleman from Georgia, Mr. Barrow.

697 Mr. {Barrow.} Thank you. I will waive.

698 [The prepared statement of Mr. Barrow follows:]

699 ***** COMMITTEE INSERT *****

|
700 Mr. {Pallone.} The gentleman from Kentucky, Mr.
701 Whitfield.

702 Mr. {Whitfield.} Thank you, Chairman Pallone, and I
703 also want to congratulate Mr. Shimkus on his new
704 responsibilities of this subcommittee, and Dr. Sharfstein, we
705 are delighted you are here to bring us up to date on the
706 implementation of this act of 2007.

707 People have already touched on a lot of these issues,
708 the safety of drugs coming into the country, the approval
709 process, whether or not there are adequate resources, and I
710 just want to point out one additional aspect of this, which
711 is a little bit different, but this committee a couple years
712 ago passed the National Prescription Drug Monitoring System
713 which I think is vitally important to health care providers.
714 We continue to struggle on getting sufficient funds to fully
715 implement this because of an unauthorized program started in
716 the Appropriations Committee but we have been working with
717 both sides of the aisle to try to address that issue and I
718 certainly look forward to your testimony on the other part of
719 this equation. Thank you.

720 [The prepared statement of Mr. Whitfield follows:]

721 ***** COMMITTEE INSERT *****

|
722 Mr. {Pallone.} Thank you, Mr. Whitfield.

723 The gentleman from Connecticut, Mr. Murphy. Well, Mr.
724 Green just walked in. Do you want to go first? Mr. Green.

725 Mr. {Green.} I would like to put my full statement into
726 the record.

727 Following our chairman emeritus and the earlier
728 statements, first I want to thank you for holding the hearing
729 and today with new FDA folks on the current status of our
730 drug safety system, and a lot of our frustrated that the
731 Senate hasn't moved on the bill but I had the opportunity
732 like a lot of members on several hearings led by Chairman
733 Pallone and Chairman Stupak, the FDA and drug safety over the
734 past 2 years. All these hearings clearly show the FDA is
735 woefully underfunded and neglected by Congress for far too
736 many years and that has left the FDA without the resources,
737 funding or technology it needs to protect the American public
738 from counterfeit or tainted drugs entering our country. This
739 committee worked over a year on FDA drug safety legislation
740 passed out of the committee. The legislation is aimed at
741 improving our drug safety system by giving FDA increased
742 resources for overseeing facility inspections by the FDA, an
743 up-to-date registry of all foreign drug manufacturing
744 facilities, country-of-origin labeling, verification of drug

745 purity and safety. It gives the FDA the ability to issue
746 fines and mandatory recalls, and also the FDA's foreign drug
747 inspection program needs to be changed and some hurdles to
748 overcome. The FDA currently does not have the authority to
749 conduct these inspections overseas and must be invited to a
750 plant to conduct inspections. That is almost like me driving
751 down the Houston freeway inviting an officer to watch me
752 while I speed. That just doesn't work in the real world.

753 And Mr. Chairman, that is why I would hope with the new
754 FDA that they will not only take their job seriously, and I
755 know they do, but also we need to provide the resources for
756 them, and I appreciate the opportunity to give the opening
757 statement and again, I would like to have my full statement
758 placed in the record.

759 [The prepared statement of Mr. Green follows:]

760 ***** COMMITTEE INSERT *****

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761 Mr. {Pallone.} Without objection, so ordered.

762 The gentleman from Texas, Mr. Burgess.

763 Dr. {Burgess.} Thank you, Mr. Chairman. I will waive

764 opening statement and reserve time for questions. Welcome,

765 Dr. Sharfstein, to our committee.

766 [The prepared statement of Dr. Burgess follows:]

767 ***** COMMITTEE INSERT *****

|
768 Mr. {Pallone.} Thank you.

769 The gentleman from Connecticut, Mr. Murphy.

770 Mr. {Murphy of Connecticut.} Thank you, Mr. Chairman,
771 and welcome, Dr. Sharfstein.

772 In your testimony, you recite some of the examples of
773 safety lapses that we have seen and you summarize by saying,
774 ``These episodes and others are not random mistakes, they are
775 driven by a common feature, which is economic incentive.''
776 And I guess it underscores what we have seen as a facet of
777 our health care system for a very long time. Too often,
778 profit is being put ahead of quality and safety, and
779 everything we do, whether it is changing the way that the FDA
780 works or whether it is the discussion surrounding health care
781 reform, has to be around reversing that phenomenon. We have
782 to be putting safety and quality first, profit and cash
783 second whether it is running the FDA, whether it is how we
784 reimburse providers or whether it is how we regulate
785 insurers. I don't begrudge drug companies from making a
786 buck. We have got a lot of very good ones in Connecticut.
787 But we should never, ever be sacrificing safety for profit.
788 We should never, ever be sacrificing quality for profit.
789 That I think is the guiding principle behind health care
790 reform and that of course I know is the principle that you

791 bring to your leadership at the FDA, and I appreciate your
792 testimony today.

793 [The prepared statement of Mr. Murphy of Connecticut
794 follows:]

795 ***** COMMITTEE INSERT *****

|
796 Mr. {Pallone.} Thank you. The other Mr. Murphy from
797 Pennsylvania.

798 Mr. {Murphy of Pennsylvania.} Thank you, Mr. Chairman.

799 I would first like to mention, unfortunately I am not
800 going to be able to remain here, Chairman and Dr. Sharfstein,
801 although I would love to hear your testimony. You know what
802 it is like, we have other things pending.

803 But I would like to bring something to your attention in
804 this, and if it not something you are able to respond to
805 today, please, I hope you can get back to me. I wanted to
806 tell you about a couple of my constituents, Russell and
807 Robely Rosewitz in Mount Lebanon. They have lived a terrible
808 tragedy. Their daughter, Hannah, was vaccinated for DPT, as
809 you know, diphtheria, pertussis and tetanus, and 2 hours
810 after she received her shot, she began experiencing seizures.
811 She was once a healthy infant and now she needs 100 percent
812 round-the-clock care. Unfortunately, adverse reactions to
813 complicated vaccines do occur and years upon years of
814 scientific evidence have shown the public health benefits of
815 vaccination are greater than the isolated, unfortunate
816 adverse action. And to encourage families to vaccinate their
817 children and ensure vaccine makers continue produce
818 lifesaving medicine, Congress passed the National Childhood

819 Vaccine Injury Act in 1986. This law compensates victims of
820 vaccination adverse effects and allows the Secretary of
821 Health and Human Services to automatically award damages when
822 a victim has experienced adverse reactions. But the DPT
823 vaccine in this case was removed from the table of vaccines
824 known to cause adverse events just 1 month prior to when
825 Hannah's family applied for compensation. After a 10-year
826 legal battle to prove that the vaccine caused Hannah's
827 seizures, the case is now before the Supreme Court. Hannah's
828 parents believe there were safer alternatives to the DPT
829 vaccine administered to their daughter. The question before
830 the Supreme Court is whether or not companies are immune to
831 civil suits if they participate in vaccine victims'
832 compensation fund.

833 Now, I am not here to argue the merits of the case. The
834 Supreme Court will decide whether or not that was the
835 Congressional intent. But this case raises an important
836 issue about vaccine safety. For example, if they are
837 imported and the FDA is not capable of inspecting the
838 manufacturing process, then where does the responsibility and
839 liability for assuring safety lie? By the way, that
840 particular DPT vaccine was later removed from the market
841 after 50 years of sales.

842 So I hope at some point you can get back to us and let

843 us know about some of these important issues. I know you are
844 deeply concerned as are we, and quite frankly, I believe that
845 contrary to what some others may say, that manufacturers also
846 want to ensure the safety of their products because they do
847 not want to see anybody harmed from these as well. so if you
848 could please get back to us and let us know how we keep up-
849 to-date on the latest scientific evidence here and how you
850 are ensuring vaccine makers are using the latest and safest
851 innovation in vaccine design.

852 Thank you so much for being here. Again, I apologize.
853 I wish I could stay because I am deeply interested in hearing
854 your testimony, but I look forward to hearing from you.

855 And with that, I yield back, Mr. Chairman.

856 [The prepared statement of Mr. Murphy of Pennsylvania
857 follows:]

858 ***** COMMITTEE INSERT *****

|
859 Mr. {Pallone.} Thank you, Mr. Murphy.

860 The gentleman from Utah, Mr. Matheson.

861 Mr. {Matheson.} Thank you, Mr. Chairman. I do
862 appreciate this hearing and look forward to the testimony.

863 In the coming weeks, I will be introducing a bipartisan
864 bill with my colleague, Representative Buyer, to develop a
865 system for the protection of our Nation's pharmaceutical
866 supplies for domestic and international counterfeiting
867 threats. Within the past 2 years, Representative Buyer and I
868 have engaged stakeholders all along the supply chain to
869 develop a workable and commonsense approach. As an integral
870 part of the stakeholder process, I also appreciate the recent
871 helpful comments from the Food and Drug Administration and
872 their suggestions of how to improve upon our approach and
873 achieve our shared ultimate goal.

874 Specifically, core elements of the bill that we plan in
875 introducing are the creation of a system by which we will be
876 able to track drugs from the time they leave the
877 manufacturing facility to the time they reach patients in the
878 pharmacy, hospital, nursing home or doctor's office.
879 Counterfeiting of drugs is a public health concern. By
880 implementing these steps now, we can go a long way towards
881 safeguarding the medicine people need to get well and stay

882 healthy.

883 Another feature will be one uniform national pedigree
884 system. By having one federal standard, I believe we can
885 ensure our Nation's drug market is efficient, it can ensure
886 products flow safely and freely throughout the country. This
887 is a guiding principle that seems to unite a majority of the
888 members of the supply chain.

889 Third, our bill will raise the standards for drug
890 wholesalers while maintaining States' rights to regulate drug
891 wholesalers. I believe this is a necessary step to ridding
892 the market of bad actors and ensuring that anyone handling
893 America's pharmaceuticals must be held to high standards.

894 Counterfeit drugs are the latest and potentially the
895 most dangerous front in the long-running battle against
896 intellectual-property crimes. In 2007, pharmaceuticals made
897 up about 6 percent of total seizures. Last year they
898 accounted for 10 percent to become the third largest category
899 with an estimated market value of \$28 million.

900 Counterfeiters are alarmingly good at their jobs. They can
901 create pills and drug packages that are so close to real
902 products that they are indistinguishable to consumers. By
903 strengthening current laws and regulations, building upon the
904 successful model signed into law in California, and by
905 creating a uniform national standard, our legislation further

906 secures the health care supply chain. This enhances our
907 country's and the Food and Drug Administration's high
908 standard for patient safety.

909 I look forward to the witness testimony. I will yield
910 back my time.

911 [The prepared statement of Mr. Matheson follows:]

912 ***** COMMITTEE INSERT *****

|

913 Mr. {Pallone.} Thank you.

914 The gentlewoman from Colorado, Ms. DeGette.

915 Ms. {DeGette.} I will submit my statement for the
916 record.

917 [The prepared statement of Ms. DeGette follows:]

918 ***** COMMITTEE INSERT *****

|
919 Mr. {Pallone.} Without objection, so ordered.

920 I think that that concludes our opening statements by
921 members of the subcommittee, so we will now turn to our one
922 witness, which we are so pleased that Joshua M. Sharfstein is
923 here today. He is the principal deputy commissioner from the
924 Food and Drug Administration, and thanks for being here, or
925 coming back to us, so if you would give us your statement, we
926 would appreciate it.

|
927 ^STATEMENT OF JOSHUA M. SHARFSTEIN, M.D., PRINCIPAL DEPUTY
928 COMMISSIONER, FOOD AND DRUG ADMINISTRATION

929 } Dr. {Sharfstein.} I thank you very much. It is good to
930 be back here. Good afternoon, Mr. Chairman and members of
931 the subcommittee. I am Dr. Joshua Sharfstein, the principal
932 deputy commissioner at the Food and Drug Administration.
933 Thank you for the opportunity to discuss the safety of the
934 U.S. drug supply.

935 Protecting Americans from unsafe or contaminated drugs
936 is not just an important responsibility of FDA, it is our
937 core charge. Drug safety was the primary reason for the
938 passage of our guiding statute. In 1937, more than 100
939 people, including many children, died from ingesting Elixir
940 Sulfanilamide, which contained the deadly poison diethylene
941 glycol. Congress then passed, and President Franklin D.
942 Roosevelt signed, the Food, Drug, and Cosmetic Act to prevent
943 future catastrophes. And yet as you know, many years later,
944 the threat of unsafe drugs remains.

945 I would like to thank the subcommittee for its
946 leadership on this issue twice. First, thank you. There
947 have been numerous hearings in this chamber have helped the
948 public understand the challenge of regulating a global

949 marketplace. And second, members of this subcommittee, along
950 with the chairman of the full committee and the chairman
951 emeritus, were the key architects of the Food and Drug
952 Administration Amendments Act of 2007, which gave the agency
953 significant new authorities and resources to address the
954 safety of drugs. In this testimony, I will cover both of
955 these important issues: import safety and the implementation
956 of the drug safety authorities in what we call FDAAA.

957 Globalization has created new risks and challenges for
958 the safety of the drug supply. Where Americans once used
959 drugs that were mostly manufactured domestically, now up to
960 40 percent of the drugs we take are imported, and up to 80
961 percent of the active pharmaceutical ingredients in these
962 drugs are from foreign sources. This makes oversight
963 significantly more difficult and leads to weaknesses through
964 which counterfeit, adulterated and misbranded products can
965 infiltrate the legitimate supply chain. That was the case
966 with the contamination of heparin in 2007 and 2008 and most
967 recently with the counterfeit Tamiflu discovered during the
968 H1N1 outbreak.

969 When the modern FDA was created in 1938, imports were a
970 tiny part of the products used in our country. Now that an
971 estimated 20 million shipments of FDA-regulated imports come
972 into this country every year, FDA must adopt a new approach,

973 one that addresses product safety by preventing problems at
974 every point in the global supply chain from the raw
975 ingredient through production and distribution all the way to
976 U.S. consumers.

977 In the food arena, this approach to prevention is
978 embodied in legislation passed by this subcommittee and the
979 full House of Representatives, which is now awaiting action
980 in the Senate. In the area of drugs and other medical
981 products, we are taking a number of steps to begin making
982 this shift as best we can with our current authorities. But
983 there is much more to be done.

984 As Secretary of Health and Human Services Kathleen
985 Sebelius noted when she appeared before this committee, FDA
986 needs additional tools to move our oversight capabilities
987 into the 21st century. FDA needs to access regulatory
988 information quickly, hold all parties responsible for the
989 quality of products in the supply chain and have reasonable
990 and reliable options for enforcement.

991 I will now turn to the drug safety authorities in FDAAA,
992 a milestone legislative achievement that has helped the
993 agency protect the public health in many ways. FDAAA
994 provided important new authorities to enhance our ability to
995 monitor approved drugs after they are marketed and to take
996 definitive action when needed. With our new authority, FDA

997 has required drug sponsors to conduct around 200 post-
998 marketing studies or trials. The agency has required safety-
999 related labeling changes in individual or classes of drugs 32
1000 times and has developed and put into place 10 evaluation and
1001 mitigation strategies with elements to support safe use into
1002 the REMS, all with the goal of better identifying and
1003 managing the risk of drugs on the U.S. market.

1004 To give you one example, FDA has established a program
1005 to support the safe use of a product, a medication in
1006 patients with a very severe bleeding disorder in which the
1007 blood does not clot because of low platelets. This
1008 medication, however, has serious side effects which include
1009 blood cancers, bone marrow fibrosis, a risk of blood clots,
1010 and even worse platelet counts when the therapy is stopped.
1011 However, it is an important treatment option for patients who
1012 have failed to respond to other therapies. By requiring
1013 elements to ensure safe use, the benefits of the drug can
1014 outweigh the risks and we can provide patients access to this
1015 critical product without being concerned that it would be
1016 used in other patients and could cause them more harm than
1017 good.

1018 I also want to know that FDAAA also reauthorized and
1019 amended the Best Pharmaceuticals for Children Act, which
1020 continues to provide valuable safety and dosing information

1021 for the use of drugs in children. As a pediatrician, I echo
1022 the comments of Congresswoman Eshoo, who worked so hard on
1023 this issue. This legislation represents a fundamental shift
1024 in prescribing for the pediatric population, even since the
1025 passage of the FDAAA legislation, 109 labeling changes
1026 related to the use of medications in children. It has been a
1027 tremendous step forward for pediatrics. We are very happy to
1028 discuss the lessons we have learned over the last 2 years in
1029 implementing FDAAA and work together to fine-tune the
1030 program.

1031 Over the last 7 decades, so much has changed in
1032 pharmaceutical science and drug regulation, yet in 2007, when
1033 scores of patients died from contamination of medications in
1034 Bangladesh, and in 2006 when children died in Panama, the
1035 culprit was familiar. It was diethylene glycol, the very
1036 same poison that had led to the passage of the Food, Drug and
1037 Cosmetic Act in 1938.

1038 FDA's work is far from done. The scientists, doctors,
1039 nurses, inspectors and other public health professionals,
1040 some of whom are here with me today, who make up FDA thank
1041 you for your support for our mission.

1042 I appreciate the opportunity to testify today and am
1043 happy to address any questions you may have.

1044 [The prepared statement of Dr. Sharfstein follows:]

1045 ***** INSERT 1 *****

|
1046 Mr. {Pallone.} Thank you, Dr. Sharfstein. I appreciate
1047 your testimony. It is good. We are just going to have
1048 questions, as you know, alternating between the Ds and the
1049 Rs, and I will start out.

1050 I mentioned in my opening statement that this committee
1051 worked very hard to pas the Food and Drug Administration
1052 Amendments Act of 2007. We call it FDAAA. And as part of
1053 FDAAA, Congress gave FDA the authority to require
1054 manufacturers to implement the so-called REMS, or Risk
1055 Evaluation Mitigation Strategies. They can require REMS when
1056 the agency believes it is necessary to ensure that a drug's
1057 benefits outweigh its risks. So I wanted to ask you
1058 initially, could you provide the committee with an update on
1059 how FDA has made use of this authority, how many REMS have
1060 been required and approved, and what has been the public
1061 health impact of REMS?

1062 Dr. {Sharfstein.} Sure. There are about 80 or 90 REMS
1063 that have been approved since the passage of the legislation.
1064 The vast majority of those are called medication guide only
1065 REMS where the REMS just consist of the fact that we have a
1066 medication guide for patients about the drug.

1067 There are about 10 REMS for 10 drugs that have what we
1068 call elements to assure safety. This is sort of the next

1069 level of control, and that can include restrictions on which
1070 pharmacies can provide the medication, whether the doctor
1071 needs special training and whether there needs to be a
1072 patient registry, and these have been used for medications
1073 for seizures, for the low platelets that we were talking
1074 about before, for medications for schizophrenia, and they
1075 really make it possible for FDA to approve the treatment
1076 because without this ability to put some restrictions and
1077 some safeguards in place, we would be very worried that these
1078 medications could do more harm than good. I think that this
1079 is very clearly a work in progress.

1080 There are certain things that in the implementation of
1081 this provision we have learned about. One of the issues is
1082 the differential treatment between generic medications and
1083 brand-name medications when it comes to communication plans.
1084 We can require that companies that make brand-name drugs do
1085 communication plans for health care professionals but when it
1086 comes to generic drugs, the FDA would have to pay for and run
1087 the communication plan.

1088 So there are a few specific issues, and I am happy to
1089 talk about them more if you want, where we think that we
1090 could be more effective with REMS. One of the others is that
1091 we have the authority to require a REM but we don't
1092 necessarily have the authority to require a specific type of

1093 REM, so that leads to negotiations that can go on for a while
1094 between the company and FDA, and recently we did a REMS for
1095 certain medications that can stimulate the bone marrow that
1096 took, you know, over a year to develop.

1097 So I think that there are definitely areas where this
1098 could be improved but in general our view is that this is a
1099 tremendously important authority and we are really making a
1100 lot of progress with it.

1101 Mr. {Pallone.} Well, I want to use an example of a drug
1102 that came to my attention, and I heard you say you have the
1103 authority to require REMS but not a particular type, and I
1104 would like you to comment on that. But let me throw this
1105 example out and then I don't know if this relates to what you
1106 said about the type., and I would like you to answer that too
1107 so maybe give me a response to that, what you mean by type
1108 that you don't have the authority but also this example. I
1109 am using as an example that there are three types of fast-
1110 acting Fentanyl, I guess is the way, or rapid-onset opioids,
1111 on the market right now, and I think it is an example where
1112 REMS would be critically important because these are
1113 extremely powerful pain relievers or opioids intended to
1114 treat breakthrough pain in adult opioid-tolerant cancer
1115 patients but a dose in a non-tolerant patient could be
1116 deadly. So it is my understanding that one of these products

1117 has a REMS with very different elements from the REMS that is
1118 required of the other two. For example, the REMS dictates
1119 that only especially trained, tested and registered health
1120 care professionals can actually prescribe the product and
1121 distribution and dispensing must be done through a specially
1122 trained and registered distributor and/or pharmacist. So
1123 explain why there would be differences between the elements
1124 of REMS for these three fast-acting Fentanyl, and does that
1125 relate back to what you said before about how you can only
1126 require the REMS but not different types?

1127 Dr. {Sharfstein.} It does relate back to that, and I
1128 don't think all of them have what we would call formal REMS.
1129 Some of them are sort of in the intermediate stage because
1130 they had a risk management program in place when the Act was
1131 passed. But I think for the purpose of your question, it
1132 definitely relates to what I was saying. The way the law
1133 works is, it says that we need to take steps to assure safe
1134 use, and the company comes to FDA with a proposal on how to
1135 accomplish that, and there may be more than one path to get
1136 to that goal. One company might say, you know, the path that
1137 we want to take is to really work through a series of just a
1138 couple pharmacies or a central pharmacy. Another might want
1139 to put particular restrictions on which physicians so that we
1140 have the responsibility of making sure that they work. We

1141 are not going to approve something that we don't think is
1142 going to hit the mark. But they won't necessarily all look
1143 exactly the same.

1144 In the case of the Fentanyl products, there is one that
1145 is for a film that does restrict the pharmacies, and there is
1146 another that is more of a lollipop that you put in the mouth
1147 and that one has an older risk management plan that we
1148 haven't announced the form REMS for.

1149 Mr. {Pallone.} Well, then, does this difference in
1150 authority make sense to you or would you like to have the
1151 power to dictate the type?

1152 Dr. {Sharfstein.} Well, I think it is very important
1153 for us to work with companies to come up with something that
1154 works and, you know, there is no question there is a lot we
1155 learn from the inner chains of companies and what we can hear
1156 from others, but I think that it is--when you find that it is
1157 taking a long time to come to agreement and when there may be
1158 a level of consistency that we would like to see if one
1159 approach really makes sense, I think that we would be very
1160 open to discussing ways that we could be able to more
1161 effectively move to closure on REMS in a way that makes sense
1162 for public health.

1163 Mr. {Pallone.} Well, my time has run out, but I have to
1164 say, this is kind of disconcerting to me, the fact that you

1165 don't have the ability to dictate the type and therefore we
1166 end up with these big differences, but I guess we will have
1167 to take it up at another time because I want to move to my
1168 ranking member, Mr. Shimkus.

1169 Mr. {Shimkus.} Thank you, Mr. Chairman. I am going to
1170 follow up on this line of questions also on the REMS.

1171 So I think the last question was, the time it takes in
1172 negotiations. We see that across the board in the federal
1173 government, and we always say that there should be a stop
1174 clock, a backstop that eventually there is a time when you
1175 have to make a decision. You let the folks negotiate but
1176 eventually you have got to get the closure. Would a backstop
1177 provision be helpful?

1178 Dr. {Sharfstein.} You know, some of the REMS that we
1179 are putting into place are coming at the time of approval,
1180 and there is a lot of incentive for the company to get its
1181 drug approved, and with REMS, the standard is, we wouldn't
1182 approve the drug without it. So--

1183 Mr. {Shimkus.} So they have an incentive to get an
1184 agreement?

1185 Dr. {Sharfstein.} Those are happening, but it is when
1186 the drug is already marketed--

1187 Mr. {Shimkus.} Well, let me go to the generic/brand
1188 name. You did allude in your opening testimony that there is

1189 a difference between your ability to effect, I thought I
1190 heard, negotiations between a generic and a brand name. Can
1191 you clarify that a little better?

1192 Dr. {Sharfstein.} Sure. That relates to this provision
1193 about communication plans, so one of the things that we can
1194 do is require a company to make certain communications to
1195 health care professionals.

1196 Mr. {Shimkus.} Why can't that be placed on the generic
1197 producer of the drug?

1198 Dr. {Sharfstein.} Someone is going to tap me on the
1199 shoulder if I get this wrong, but I think that the law
1200 doesn't allow us to do that for generics.

1201 Mr. {Shimkus.} So the issue would be a responsibility
1202 for us to address if we are going to move forward to help
1203 assist that. Okay. Thanks.

1204 The other question I wanted to talk about was also
1205 alluded to in my opening statement, and in the FDA Week
1206 Inside Washington on January 22nd, on the second page it
1207 says, ``As FDA struggles with whether to relax conflict-of-
1208 interest policies that have made it difficult to fill slots
1209 in the pharmaceutical advisor panels,' ' so you all, the FDA,
1210 is saying we have problems filling these slots. We have a
1211 tendency, the unforeseen consequences of legislation, and I
1212 think what we are seeing to some extent is these advisory

1213 panels because of which we can't fill. We pulled up from the
1214 website gastrointestinal drug advisory committee where there
1215 is five openings that you all identified. Our office has
1216 personal experience with someone who had a catastrophic death
1217 because of this. What do you tell us and is there anything
1218 we need to do ease legislatively? I mean, the response was
1219 to make sure there was no conflict of interest and people
1220 weren't benefiting from their advisory role while benefiting
1221 financially but we have got to be careful that we don't go
1222 overboard and that we lose all this expertise. You alluded
1223 to some of that in your opening statement. What can you tell
1224 us and what advice can you give us?

1225 Dr. {Sharfstein.} Sure. Well, this is an issue which
1226 clearly requires a balance and it is a balance that Congress
1227 faced in writing the law, it is a balance that the agency
1228 faces. On one hand, we clearly would prefer advisors who
1229 don't have conflicts of interest and it is really important
1230 for us to look for qualified advisors who don't have a
1231 conflict of interest. On the other hand, the agency needs to
1232 get the best advice in order to make the best decisions, and
1233 there are certain situations where the people who have the
1234 best advice and unique expertise are going to have conflicts
1235 of interest. We have got to somehow, you know, balance those
1236 two things, and I think the bill did a very good job and

1237 gives the agency some leeway to figure out how to do that,
1238 and within the scope of what the legislation has done, it
1239 gives us the ability to figure out the right spot, and I will
1240 be more specific. The legislation sets a cap on the number
1241 of waivers that we can have for advisory committees, and that
1242 cap goes down over time. I think it is somewhere in the
1243 ballpark of 13 percent. But we are right now well under
1244 that. I think we are granting waivers, like 4 to 5 percent
1245 of the people who are on the advisory committees are getting
1246 waivers. So without changing the law, we have the ability if
1247 we think that it is important to get certain members to grant
1248 more waivers. If--

1249 Mr. {Shimkus.} Well, let me ask a question because my
1250 time is running. On this from the FDA website, you have
1251 quite a few vacancies listed there. Now, I don't know what
1252 to relate that to you because I didn't pull up the previous
1253 month or I didn't look at last year's. Is this excessive
1254 vacancies? I mean, we have got anywhere from 21 in one of
1255 the areas. Well, in fact, pharmaceutical science, there are
1256 21 vacancies. Advisory committee reproductive health drugs,
1257 there are eight vacancies. There are nine in drug safety and
1258 risk management. That looks like there is a lot of
1259 vacancies, and if that is, then maybe we need to--

1260 Dr. {Sharfstein.} Right. Well, I don't like vacancies

1261 on the advisory committees. We definitely want to fill them.
1262 I actually asked the advisory committee dean whether they
1263 felt that there were more now, and they said that they have
1264 always had vacancies. They couldn't say that there are more
1265 now. Having said that, I think it is important for us to
1266 strike the right balance, and it is not a question for the
1267 statute because the statute gives us more room. If we feel
1268 the right decision is to grant people more waivers, we have
1269 got plenty of room under the statutory cap. It is really up
1270 to what the people at FDA want to do. I think the way Dr.
1271 Hamburg and I are looking at this is, there are situations
1272 where it is important for us to get the best advice from
1273 someone who requires a waiver. We need to take into account
1274 the type of conflict they may have, the type of decision that
1275 is being asked for and make a decision, but we understand
1276 that that will be necessary.

1277 Mr. {Shimkus.} Thank you, Mr. Chairman.

1278 Thank you, Doctor.

1279 Mr. {Pallone.} Thank you.

1280 Chairman Dingell.

1281 Mr. {Dingell.} Thank you.

1282 Dr. Sharfstein, I want you to understand these are
1283 friendly questions. I want yes or no answers. You are
1284 familiar with the heparin crisis which caused 81 American

1285 deaths. Does FDA currently have the adequate resources,
1286 personnel authorities to prevent another heparin crisis?

1287 Dr. {Sharfstein.} No.

1288 Mr. {Dingell.} Do you have the ability to control the
1289 safety of imported pharmaceuticals?

1290 Dr. {Sharfstein.} Not to the extent we would like.

1291 Mr. {Dingell.} Do you have the authority and resources
1292 to address the safety of components being now imported into
1293 this country?

1294 Dr. {Sharfstein.} No, not to the extent we would like.

1295 Mr. {Dingell.} Do you have the authorities and
1296 resources to see to it that good manufacturing practices are
1297 properly observed overseas?

1298 Dr. {Sharfstein.} No, not to the extent we would like.

1299 Mr. {Dingell.} Would you please submit to the committee
1300 the number of people that you have at the different ports to
1301 assure the safety and the inspection of pharmaceuticals
1302 coming into this country, and also would you give us the
1303 number of people that you need to see to it that this is
1304 done? Please submit that for the record.

1305 Dr. {Sharfstein.} Sure.

1306 Mr. {Dingell.} Do you have adequate authority to keep
1307 out unsafe drug shipments at the border?

1308 Dr. {Sharfstein.} No.

1309 Mr. {Dingell.} Do you have authority to require
1310 manufacturers to assure the safety of their supply chain?

1311 Dr. {Sharfstein.} No.

1312 Mr. {Dingell.} Do you have the authority to see to it
1313 that good manufacturing practices are observed in this
1314 country in both food and drugs and abroad, yes or no?

1315 Dr. {Sharfstein.} Not to the extent we would like, no.

1316 Mr. {Dingell.} Does FDA have the authority to require
1317 mandatory drug recalls?

1318 Dr. {Sharfstein.} No.

1319 Mr. {Dingell.} Now, do you have authorities, or rather
1320 do you have cooperative management agreements or letters of
1321 cooperation between Food and Drug, the Department of Homeland
1322 Security and other agencies that have personnel at the points
1323 of entry?

1324 Dr. {Sharfstein.} We do work closely with other
1325 agencies at the point of entry.

1326 Mr. {Dingell.} Do you have the--

1327 Mr. {Pallone.} Mr. Dingell, excuse me. Can you speak
1328 more into the mic because I can barely you.

1329 Dr. {Sharfstein.} I am sorry about that.

1330 Mr. {Pallone.} That is all right.

1331 Mr. {Dingell.} Do you have adequate authority to
1332 require mandatory drug recall?

1333 Dr. {Sharfstein.} No.

1334 Mr. {Dingell.} Do you need that authority?

1335 Dr. {Sharfstein.} We would like that authority, yes.

1336 Mr. {Dingell.} Would you like it, or do you need it?

1337 Dr. {Sharfstein.} I would say we need it.

1338 Mr. {Dingell.} You have also the legislation down there

1339 in H.R. 759 which gives you additional authorities that was

1340 introduced by Mr. Pallone, Mr. Stupak, Ms. Sutton, Ms.

1341 DeGette and I. That would give you significant authorities

1342 to address your current lack of capability. Is that right?

1343 Dr. {Sharfstein.} That legislation has some very

1344 important elements, yes.

1345 Mr. {Dingell.} It would also give you the resources

1346 which you need of a financial character by enabling you to

1347 collect fees from both manufacturers of food and from

1348 pharmaceuticals. Is that right?

1349 Dr. {Sharfstein.} It does have that provision, yes.

1350 Mr. {Dingell.} And you can do that both at home and

1351 abroad. Is that right?

1352 Dr. {Sharfstein.} I believe so, yes.

1353 Mr. {Dingell.} And are those resources and those fees

1354 included in your budget submissions to the Congress that the

1355 Administration has submitted?

1356 Dr. {Sharfstein.} I don't believe so.

1357 Mr. {Dingell.} You don't? I understood they were.
1358 Dr. {Sharfstein.} I am sorry. For food, it is, yes.
1359 Mr. {Dingell.} For food?
1360 Dr. {Sharfstein.} Yes, for food.
1361 Mr. {Dingell.} How about pharmaceuticals?
1362 Dr. {Sharfstein.} I don't believe so, no.
1363 Mr. {Dingell.} But that is built into your budget with
1364 regard to food?
1365 Dr. {Sharfstein.} Correct.
1366 Mr. {Dingell.} Now, it is a curious situation that I
1367 have observed that you were in the awkward place at Food and
1368 Drug of having somebody being able to bring unsafe foods into
1369 the United States and you can't catch them at the point of
1370 entry. But you also have the problem if you do catch them,
1371 you don't have authority to seize, impound or to destroy. Is
1372 that right?
1373 Dr. {Sharfstein.} Yes.
1374 Mr. {Dingell.} So you send them back out. That is
1375 right?
1376 Dr. {Sharfstein.} I believe so. Often that is what
1377 happens.
1378 Mr. {Dingell.} And they then bring them back in. Is
1379 that right? Through another port of entry.
1380 Dr. {Sharfstein.} I think they can try, yes.

1381 Mr. {Dingell.} Do you have that same problem with
1382 regard to pharmaceuticals?

1383 Dr. {Sharfstein.} Yes.

1384 Mr. {Dingell.} So that problem exists in both places.
1385 Now, you have problems with unsafe commodities being brought
1386 in, foods and pharmaceuticals, and you also have some that
1387 are overaged, improperly stored, contaminated, filthy,
1388 improperly packaged, counterfeit, and you also have some that
1389 are full of inert substances. You mentioned talcum powder
1390 and things like that coming in. Do you have authority to
1391 deal with those?

1392 Dr. {Sharfstein.} We have some authorities but not
1393 enough.

1394 Mr. {Dingell.} Do you have enough?

1395 Dr. {Sharfstein.} We don't have enough.

1396 Mr. {Dingell.} As proven by heparin.

1397 Dr. {Sharfstein.} Yes.

1398 Mr. {Dingell.} And of course, you have coming into this
1399 country from China on a fairly regular basis, from Mexico and
1400 other places, unsafe foods and pharmaceuticals and I can
1401 recall mushrooms, I can recall berries, I can recall tomatoes
1402 and jalapeno peppers. I can recall the heparin scare and a
1403 large number of others. This an ongoing and continuing
1404 problem, is it not?

1405 Dr. {Sharfstein.} Absolutely.

1406 Mr. {Dingell.} And you lack the Congressional support
1407 in both authority and money to do the job that you need to do
1408 to protect the American people. Isn't that right?

1409 Dr. {Sharfstein.} Well, we very much want to do more.

1410 Mr. {Dingell.} I don't want you to be afraid to say
1411 that we haven't given you the authority you need--

1412 Dr. {Sharfstein.} We want more authority.

1413 Mr. {Dingell.} --if it is the truth because we are
1414 going to try and get it for you.

1415 Mr. Chairman, I thank you for your courtesy.

1416 Mr. {Pallone.} Thank you, Mr. Dingell.

1417 The gentleman from Pennsylvania, Mr. Pitts.

1418 Mr. {Pitts.} Thank you, Mr. Chairman. Going back to
1419 this concern for counterfeit drugs, there is a growing global
1420 threat from counterfeit medicines. For example, in 2008,
1421 counterfeit medicine article seizures rose 118 percent in the
1422 European Union, and 8.9 million counterfeit medicine articles
1423 were seized by E.U. customs officials. Over just a 2-month
1424 period in 2008, the European Commission seized 34 million
1425 counterfeit pills including antibiotics, cancer, cholesterol
1426 and antimalaria medicines. Does this staggering increase in
1427 counterfeiting in places like the E.U. present concerns to
1428 the United States, and can you quantify it for us?

1429 Dr. {Sharfstein.} It definitely does present concerns,
1430 and I think, you know, the problems with counterfeit
1431 products, first of all, they can be dangerous in and of
1432 themselves, but second of all, they can fail to treat the
1433 condition that the patient has and the patient can get much
1434 sicker if they are taking medicines that are ineffective or
1435 subpotent. So it presents a serious problem and I think the
1436 problems that we see globally are very much a potential
1437 threat to the United States.

1438 In terms of quantifying, I can't unfortunately quantify
1439 how many counterfeits are in the United States. We do that
1440 reports that we have been investigating have gone up over the
1441 last 2 years so that our investigators at FDA are hearing
1442 about this problem more, but we do think that in general we
1443 do not have a huge problem with counterfeit in part because
1444 we have a closed--a generally closed system. When pharmacies
1445 order medications, they can get them through licensed
1446 wholesalers, they can get them from licensed manufacturers,
1447 but we know that there are ways for other products to enter
1448 the legitimate supply chain and that makes us concerned. You
1449 may remember in 2003 there were several million, I think,
1450 pills of Lipitor that were counterfeit that got into
1451 pharmacies, and there are other problems too. Recently we
1452 had a situation where a truck full of insulin was stolen and

1453 then the insulin started showing up later, and we didn't know
1454 whether the insulin had been adequately refrigerated and it
1455 had sort of reentered the supply chain in a way that could
1456 potentially have been quite dangerous to patients. So there
1457 is no question that the problems seen around the world are of
1458 concern to us and we think that we do need additional work
1459 here to really secure the supply chain in the United States
1460 against this potential threat.

1461 Mr. {Pitts.} When the U.S. authorities interdict
1462 counterfeit drugs here in the United States, what occurs?
1463 What is done with those drugs?

1464 Dr. {Sharfstein.} When we actually find the drugs and
1465 we know that they are counterfeit? I am not sure, but I
1466 think they are destroyed. If we identify products that are,
1467 you know, in the supply chain that are counterfeit, I can
1468 double check, but I think they get destroyed.

1469 Mr. {Pitts.} Where are the major gaps, in your opinion,
1470 as far as interdiction of counterfeit drugs here in the
1471 United States?

1472 Dr. {Sharfstein.} The major gap is that we don't
1473 require a pedigree for the product to go all the way from the
1474 manufacturer to the final sale. If people are ordering from
1475 the right places, they can get medicines that are safe and
1476 not counterfeit. There are opportunities for counterfeit

1477 products to potentially get in without a clear requirement
1478 where we are holding each person in the chain responsible for
1479 making sure that they only have legitimate products. So the
1480 kind of provisions that we would like to see are that each
1481 person in the supply chain as it goes from the manufacturer
1482 to the wholesaler, they are responsible. If they let
1483 something in that is not legitimate, then there is a real
1484 penalty for that and every single person in the supply chain,
1485 every single company is responsible for making sure those
1486 products are legitimate, and that would require a new
1487 authority.

1488 Mr. {Pitts.} Do you have a regular system or procedure
1489 for testing drugs that are coming in the United States that
1490 you pursue?

1491 Dr. {Sharfstein.} We do do some tests. We do some
1492 targeted sampling based on where we think the risk is but it
1493 is really only a small part of the solution, the testing.
1494 There is no way we could test our way out of the problem just
1495 because of the sheer volume of imports.

1496 Mr. {Pitts.} What is the greatest need that you have as
1497 an agency as far as addressing this problem?

1498 Dr. {Sharfstein.} I think the greatest need is the
1499 ability to enforce the supply chain requirements across the
1500 supply chain. You know, we have been working on and are

1501 about to come out with a process for unique numbers for each
1502 kind of bottle of pills but we don't have the authority to
1503 say you are responsible for making sure that every person
1504 when they get the medication that it is legitimate
1505 medication. That is what we would like.

1506 Mr. {Pitts.} Thank you, Mr. Chairman.

1507 Mr. {Shimkus.} Would the gentleman yield for one
1508 second?

1509 Mr. {Pitts.} I will yield.

1510 Mr. {Shimkus.} But that discussion was all about the
1511 legal distribution chain. You haven't even addressed the
1512 illegal websites and the illegal mail order sites that if
1513 some senior goes on a website, clicks on 90-day supply of
1514 Lipitor and it gets mailed to them, there is no way. We
1515 don't know. Is that correct? I mean, that was a good
1516 discussion about legal process, of all the good actors. I
1517 think the concern that most of us have is the bad actors.

1518 Dr. {Sharfstein.} We have brought some cases recently
1519 against bad actors and legitimate chain and the ability of
1520 products to infiltrate the legitimate supply chain is
1521 something that we need to be very vigilant about, but you are
1522 right. You are raising a separate issue that is very
1523 important and I think this gets a little bit to the issue
1524 that Congressman Buyer and Congressman Matheson were raising

1525 about destruction authority and other things, and that is
1526 also an issue that we care about.

1527 Mr. {Shimkus.} Yes, and I only bring it up because
1528 there is really--I agree with your statements but I think for
1529 both of us it is that other issue that has us more concerned
1530 than anything.

1531 I appreciate the gentleman yielding.

1532 Mr. {Pitts.} Thank you, Mr. Chairman. I yield back.

1533 Mr. {Pallone.} Thank you.

1534 The gentlewoman from the Virgin Islands, Ms.
1535 Christensen.

1536 Mrs. {Christensen.} Thank you, Mr. Chairman, and thank
1537 you for holding this hearing, and welcome back, Dr.
1538 Sharfstein.

1539 First of all, I can attest to the fact to the answer to
1540 Chairman Dingell's question about collaboration with other
1541 agencies because Customs and Border Protection acts on behalf
1542 of FDA at the Puerto Rico transit station--and your staff
1543 knows where I am going, I can see them nodding--to confiscate
1544 medication going to and from the Virgin Islands, but I am not
1545 sure if you are aware of this problem but I have to bring it
1546 up, and your staff is aware of it. We are outside of the
1547 U.S. customs zone. We are fully part of the United States.
1548 We are outside of the U.S. customs zone. All of our

1549 pharmacists are U.S. trained, and while they are locally
1550 licensed, they have their U.S. DEA license and are governed
1551 like the Virgin Islands are in general by all the U.S. laws
1552 and they are governed by all FDA rules and regulations. They
1553 order their medication including my hospital pharmacies,
1554 which are also overseen by JCAHO and CMS. They order their
1555 medication from distributors in the States. These are either
1556 U.S.-made medication or something that FDA has approved for
1557 importation into the United States. They cannot send it back
1558 to their distributor. They are prohibited because we are
1559 outside of the customs zone from sending it back to their
1560 distributor if they are oversupplied, if they are damaged, if
1561 they are expired. It is an extreme burden on my pharmacies.
1562 My hospital pharmacies were cited by one of the certifying
1563 agencies for having too many expired drugs in the pharmacy.

1564 If we could craft some narrow language, and we have
1565 tried, that would just allow our pharmacies to send their
1566 medication back to the place that they brought it from, would
1567 you be willing to take a look at that?

1568 Dr. {Sharfstein.} Absolutely, and I do recall your
1569 raising this issue before and I know that there are people at
1570 FDA who have been actually in touch with entities in the
1571 Virgin Islands to work on this.

1572 Mrs. {Christensen.} Yes, we have had some conference

1573 calls.

1574 Dr. {Sharfstein.} So I am extremely sympathetic to the
1575 situation that they were in and I think we would like to find
1576 a solution.

1577 Mrs. {Christensen.} I appreciate that. And the other
1578 question is about importation. Well, I don't consider ours
1579 importation or reimportation of drugs because they are U.S.-
1580 made drugs, U.S. pharmacies, it is U.S. jurisdiction. But
1581 Congress and FDA acknowledge that there have been numerous
1582 safety issues related to drug importation, and I voted
1583 against it when I had the opportunity. One of the issues I
1584 am concerned about from a safety perspective is the
1585 importation of products subject to the REMS requirements that
1586 have been discussed in other ways here today. Does the FDA
1587 support this posture that they can be reimported subject to
1588 the REMS requirements, and how does FDA view the
1589 reimportation safety concerns as they relate to the REMS
1590 process? And would FDA ever under any circumstances consider
1591 an exemption of certain drugs under reimportation policy if
1592 it would lead to the obfuscation of the REMS requirements? Is
1593 that clear?

1594 Dr. {Sharfstein.} I think I understand. You know, the
1595 Administration supports finding a safe and effective way for
1596 patients to obtain medications from other countries but it is

1597 a challenge because there are a lot of safety concerns, and
1598 certainly one of the safety concerns that would have to be
1599 overcome is trying to figure out what to do with the products
1600 that have a narrow therapeutic window. Another way of saying
1601 that, where you are worried that they could actually do more
1602 harm than good where you have a REMS in place or other
1603 medicines where it depends on how they are used, and that
1604 very much would be an issue for us, I think, and we would not
1605 want people to get medications without the kind of controls
1606 that are needed to ensure their safe use.

1607 Mrs. {Christensen.} Is there something that we need to
1608 do to, or is there something the improvements that need to be
1609 made or becoming more assured of the safety and use of the
1610 REMS process? Is there something that we need to do? Is
1611 there something that FDA can do administratively?

1612 Dr. {Sharfstein.} I don't think there is an issue
1613 before Congress on this point right now, but if there is, we
1614 can be in touch. But I think the premise of your question
1615 that there are certain drugs we have to be very careful
1616 about, that does underlie FDAAA and that is something that
1617 FDA feels very strongly about.

1618 Mrs. {Christensen.} Thank you.

1619 Thank you, Mr. Chairman.

1620 Mr. {Pallone.} Mr. Burgess.

1621 Dr. {Burgess.} Thank you, Mr. Chairman, and again, Dr.
1622 Sharfstein, thank you for being with us and staying with us
1623 late this afternoon.

1624 On the issue of resources, we have heard I don't know
1625 how many times in this committee and the Subcommittee on
1626 Oversight and Investigations about inadequate resourcing of
1627 the agency and that the resources haven't kept pace with the
1628 increase in demands placed on the FDA, the fact that now you
1629 are having to really function as almost a global agency with
1630 budgets that 10 years ago seemed adequate but now you seem
1631 significantly underfunded. It always happens. In fact, I
1632 was on this committee for several years before I realized
1633 that the funding actually comes from the USDA appropriations
1634 bill, not through HHS. That funding structure something that
1635 you all have to deal with but should we consider some way
1636 modernizing how Congress funds the FDA?

1637 Dr. {Sharfstein.} You know, I think over the last few
1638 years FDA has gotten a tremendous amount of new resources and
1639 the subcommittees, both of which I testified at last year,
1640 were extremely supportive of the agency, and the agency
1641 really has been using those resources to develop a real
1642 foundation for the future on these issues. I think that it
1643 is not just resources that are an issue when it comes to an
1644 issue like safe drugs and imported safe drugs. We need to be

1645 able to secure the supply chain, hold people in the supply
1646 chain accountable, set good standards--

1647 Dr. {Burgess.} I don't mean to interrupt you, but I
1648 will run out of time here.

1649 Mr. Chairman, if you will just make note that the
1650 witness testified that they have all the money they need and
1651 Congress does not need to supply any more.

1652 But it begs the next question, and I know it is a drug
1653 safety hearing, but you must get a tremendous volume of new
1654 drug applications. Is that correct?

1655 Dr. {Sharfstein.} I think that there is a tremendous
1656 amount of work when it comes to the new drug applications and
1657 additional indications for existing drugs, so there are a lot
1658 of different types of applications that the agency has to
1659 handle, yes.

1660 Dr. {Burgess.} Do you have any idea as to the magnitude
1661 of the backlog?

1662 Dr. {Sharfstein.} Well, there is not really a backlog
1663 when it comes to the new drug applications. We are on a
1664 clock and we do our best to hit the goals of reviewed
1665 timetables. When it comes to generic drugs, there is a
1666 backlog. It is a different type of review process, a
1667 different type of application, and there are several thousand
1668 applications that are kind of in the queue to be approved.

1669 Dr. {Burgess.} Well, for example, we got funding for
1670 the National Institute of Health in the stimulus bill, a
1671 significant amount of money, and the idea was, of course, to
1672 generate new research and new discoveries. Do you have what
1673 you need to keep pace with the rapidity of those new
1674 discoveries and new developments?

1675 Dr. {Sharfstein.} That is an excellent question, and
1676 slightly different than just reviewing the applications. I
1677 think that FDA, and Dr. Hamburg has been very engaged on this
1678 issue. We feel that the agency needs to do a lot more to be
1679 able to review the products of the 21st century, and that
1680 involves updating and upgrading our scientific standards for
1681 review and it involves a lot of needed investments, not just
1682 by the government but by academia and others, in what we call
1683 regulatory science, which is the science of how you know
1684 whether something is safe and effective. For example, we
1685 want to be able to identify a safety problem very quickly in
1686 the lab and not have a company spend all this time and money
1687 in development and then find the safety problem; let us
1688 identify that quickly. If there is a way on the
1689 effectiveness side to find a marker that a drug will be
1690 effective without having to require a tremendous and long
1691 amount of time before we show that it works, that is just an
1692 enormous benefit to the drug development process, and that is

1693 separate from the review of any one application but that area
1694 of regulatory science and those kinds of investments are
1695 extremely important. The President's budget for the first
1696 time has an initiative on that but over the course of the
1697 future this is where we think that there needs to be a lot
1698 more done.

1699 Dr. {Burgess.} Well, just as a case in point, a real-
1700 world example, yesterday the Alzheimer's association was on
1701 the Hill visiting every office asking for a significant plus-
1702 up in funding for Alzheimer's research, a noble goal, a
1703 worthwhile goal. This comes on top of the reauthorization we
1704 did at NIH back in 2006, level funding of \$30 billion a year
1705 to increase 5 percent a year. I don't know that we have ever
1706 met those goals. But then the \$10 billion in addition to the
1707 authorized amount that we gave in the stimulus bill, now we
1708 are asking at least in the Alzheimer's legislation that Mr.
1709 Markey has, another \$2 billion to put forward to the research
1710 for new Alzheimer's drugs. Can you guys keep up with that if
1711 you have that kind of push in the pipeline for new products
1712 coming down?

1713 Dr. {Sharfstein.} I will tell you the analogy that Dr.
1714 Hamburg uses when she talks about is of a rower with one very
1715 muscular arm and one kind of scrawny arm, and if we are
1716 pouring a lot into basic medical research but we don't have

1717 the science to decide whether the products are safe and
1718 effective, then you don't get a system that moves forward.
1719 It kind of goes in circles. You don't see the treatment--

1720 Dr. {Burgess.} And are you aligning yourself to that,
1721 to making a more muscular--

1722 Dr. {Sharfstein.} Yes. And in fact, a few weeks ago,
1723 Secretary of Health Kathleen Sebelius went out to NIH with
1724 Dr. Collins and Dr. Hamburg and we announced a whole set of
1725 collaborations with NIH to bridge the gap so that it is not
1726 that money goes to NIH and then here is FDA on the other side
1727 but that we are going to have in addition to a public meeting
1728 and open docket for suggestions on how we can work together,
1729 we can have a council that is going to meet and oversee a
1730 whole new range of collaborations, and for the first time
1731 both agencies are putting in money to fund this kind of
1732 research in academia around regulatory science.

1733 Dr. {Burgess.} But at the present time, to the extent
1734 that those new discoveries are arriving on your doorstep,
1735 there is no backlog? Those applications are receiving timely
1736 review and--

1737 Dr. {Sharfstein.} It is not a question of the
1738 timeliness of the review, it is the tools we have. We would
1739 like to upgrade the tools we have for the new types of
1740 products.

1741 Dr. {Burgess.} Are all those applications online? Is
1742 that all in an electronic database?

1743 Dr. {Sharfstein.} We are moving towards full electronic
1744 submission but the problem is--

1745 Dr. {Burgess.} So the applications are paper
1746 applications?

1747 Dr. {Sharfstein.} In some cases, but I think we are
1748 moving pretty quickly to electronic, but I think the issue
1749 is--

1750 Dr. {Burgess.} But, you know, here, and I will just
1751 give you a real-world example. If this were a class-action
1752 lawsuit, for example, a big law firm, any of the big law
1753 firms downtown or in downtown Dallas would hire the people to
1754 digitize that data and then have it done within a couple of
1755 months' time in order to make their case either pro or con in
1756 the legal action. This is something that is done all the
1757 time but outside organizations. The FDA should be the leader
1758 on this.

1759 Dr. {Sharfstein.} There is no question that we need to
1760 have electronic data submissions, and we want to do it in a
1761 way that that the data comes in so that it can be analyzed
1762 very efficiently. The challenge is, it is not so much the
1763 review of the application that comes in, it is that we don't
1764 get the applications, products don't make it all the way to

1765 the point where they have enough evidence to get to FDA's
1766 doorstep. That is the kind of gulf we are trying to cross by
1767 working with the NIH, that they do the research, they go, oh,
1768 maybe this product works. Then how do you get it from there
1769 to the point where you can do clinical trials? I mean, how
1770 do you--what is the right kind of clinical trial to do, what
1771 is the right tool to know, how do you get the companies in,
1772 ready to invest.

1773 Dr. {Burgess.} And after companies have made that
1774 investment and they come to you for the approval, that is the
1775 part of the chain that I am worried about, that you have the
1776 tools you need to be able to get these things to the people
1777 who so desperately need them.

1778 Dr. {Sharfstein.} I agree with that completely, and we
1779 also want more drugs to come to our doorstep than are coming
1780 now, more applications. We would like to see that happen
1781 because there are a lot of people who have diseases that need
1782 medicine.

1783 Dr. {Burgess.} I don't know what time frame would be
1784 the correct unit, but how many new drug applications per
1785 month or quarter or fiscal year?

1786 Dr. {Sharfstein.} I think it is a ballpark of about 25
1787 new, completely new drugs getting approved by the FDA roughly
1788 every year.

1789 Dr. {Burgess.} How many applications, though, how many
1790 new drug applications that seek approval will you get a year?
1791 So 25 make it through the--

1792 Dr. {Sharfstein.} This is Dr. Woodcock from FDA. About
1793 30 to 35. You know, that is my point about we would like to
1794 see more. But to do that, we have to help the discoveries
1795 bridge the way to the point of FDA application.

1796 Dr. {Burgess.} Interestingly, Dr. Zerhouni at NIH 8
1797 years ago told me that they were working on, I think it was
1798 no fewer than 88 drugs to deal with obesity. With that kind
1799 of pressure in the research pipeline, you guys are going to
1800 have to be really precise and efficient to be able to handle
1801 that kind of research coming your direction.

1802 Dr. {Sharfstein.} I think that is true. What we want
1803 to do it help NIH as it is investing in those 88 or however
1804 many it is products, sue that investment so it is pushing the
1805 products closer to an FDA application rather than, you know,
1806 being all these different steps to get there. And so that is
1807 one of the things we are going to work with them on. If NIH
1808 is going to pay for a trial, what is the right way to design
1809 that so that we get really good usable data for an
1810 application. So it is not so much once the application comes
1811 in, we need better tools to review them, but it is how you
1812 get more applications of promising therapies. That is what

1813 Dr. Hamburg is extremely committed to and why we are doing
1814 this big product with NIH.

1815 Mr. {Pallone.} Dr. Burgess, we are actually going to
1816 have a second round, so I just want you to know.

1817 Mr. Braley.

1818 Mr. {Braley.} Thank you.

1819 Dr. Sharfstein, I want to start with a word that we hear
1820 still today frequently called mail order drugs, and in this
1821 Internet age, isn't that somewhat of an oxymoron? There is a
1822 very specific reason I am asking you this question. We heard
1823 our colleague Dr. Gingrey spend his time that he had in his
1824 opening instead of talking about drug safety blasting the
1825 health care legislation we are considering right now. But
1826 when you have 47 million Americans without access to health
1827 insurance and a lot of people losing their jobs with
1828 employer-based health care coverage and you have got people
1829 who are in prescription drugs who suddenly have no means
1830 because they can't afford to pay their COBRA payments without
1831 a job who go online like many of us and surf for some answer
1832 to their medication needs. There are endless websites out
1833 there of predatory companies looking to see what may or may
1834 not be an actual pharmaceutical to somebody desperate for
1835 treatment. Would you agree with that?

1836 Dr. {Sharfstein.} I think it is a recipe for tragedy.

1837 Mr. {Braley.} And we all know that the problem is, your
1838 agency has limited resources you are dealing with. Research
1839 applications, you are dealing with enforcement issues
1840 overseas, you are dealing with enforcement and compliance in
1841 domestic manufacturers. So I guess my question is, if we do
1842 nothing to improve access and affordability for prescription
1843 drugs, aren't we just inviting chaos as consumers look to
1844 these disreputable online companies, and I am not lumping all
1845 online companies into that category but there are plenty of
1846 them out there. Aren't desperate people going to resort to
1847 desperate measures to try to solve their health care needs?

1848 Dr. {Sharfstein.} I think there is no question that
1849 health care reform that gets more Americans access to
1850 prescription drug coverage is extraordinarily important for
1851 avoiding the kinds of problems we are talking about.

1852 Mr. {Braley.} Thank you. One of the things that I
1853 wanted to talk to you about was your remarks about the
1854 Sentinel Initiative because I am interested in learning more
1855 about that, what it was based upon, what model it was based
1856 upon and how it is going to achieve the objective of a
1857 national integrated electronic system for monitoring medical
1858 product safety. And Dr. Christensen mentioned JCAHO, which
1859 is looked to by many people as a forerunner in setting up a
1860 Sentinel Event Reporting System with root cause analysis and

1861 an integrated approach to trying to get to the bottom of
1862 patient safety issues. In its first 10 years of existence,
1863 the Sentinel Event Reporting System averaged annually 300
1864 reports, which is an abysmal statistic given the high number
1865 of medical errors that occur in this country every year. So
1866 tell me how this Sentinel Initiative that FDA is pursuing is
1867 going to achieve the objective and the access data goals that
1868 you have identified and truly reach a comprehensive reporting
1869 system that is going to get to the heart of patient and drug
1870 safety?

1871 Dr. {Sharfstein.} Sure. I appreciate the question.
1872 What we are doing and the sentinel system at JCAHO are very,
1873 very different. They have the same word but they are very,
1874 very different. They are, I think what you are describing is
1875 sort of a reporting system where people actually have to
1876 report. That is not what the FDA's sentinel system is based
1877 on. The concept is that there are data resources out there,
1878 generally large, integrated health systems, where you have
1879 data for millions of Americans who are taking medications and
1880 that we can use that information in a way that is completely
1881 protective of their confidentiality. In fact, the data we
1882 are looking at doesn't come to the federal government, it is
1883 done by the systems themselves. They look into their system
1884 to answer key questions about drug safety and over time we

1885 put into place a system to look in advance. In other words,
1886 if we have a concern that a particular product might cause a
1887 problem, we can program it so that if we see that when
1888 patients are getting it, it automatically lets us know. That
1889 is the long-term goal. So--

1890 Mr. {Braley.} Let me just interrupt you briefly to add
1891 another component to this, because my time is running out.
1892 There has been a big push not only in the American Recovery
1893 and Reinvestment Act that we passed earlier in 2009 but also
1894 in this health care bill that we have been talking about to
1895 move aggressively toward electronic medical records, which we
1896 all know is one way to try to deal with drug interactions and
1897 to dramatically reduce the number of drug errors. So is that
1898 another reason why getting it right on EMR is so important in
1899 addressing some of the goals of this Sentinel Initiative?

1900 Dr. {Sharfstein.} Absolutely. If we have more patients
1901 with effective medical records and we are working with the
1902 Office of the National Coordinator to make sure the standards
1903 on those records are good for this kind of work, then we will
1904 be able to tap into more Americans' experiences with
1905 medications to identify whether there are legitimate safety
1906 issues that we have to respond to. So where we are now if
1907 that we are working with certain health care systems that
1908 have data and we are setting up basic standards so that they

1909 will be able to respond to inquiries. It is a system where
1910 we don't need anyone to volunteer anything. Once we have a
1911 question, they go out and they just program their data set
1912 and they tell us whether they are seeing that, and it is a
1913 network so it is not just one big database. It is, you know,
1914 we are going to go up to New England and there is a data set
1915 there, there is a data set in California, and we are going to
1916 be able to look in a much quicker way than we can do to see
1917 if there are safety signals emerging. And there has been a
1918 lot of work done at FDA. We are constantly reviewing how
1919 this is going to make sure we are keeping it on track. It is
1920 a very ambitious project but there has been a tremendous
1921 amount of leadership at the agency on it and we are very
1922 appreciative of the support we have gotten.

1923 Mr. {Braley.} Thank you. I will yield back, and I
1924 would just encourage you to keep us informed on the progress
1925 you are making in the rollout of that system.

1926 Dr. {Sharfstein.} Sure.

1927 Mr. {Pallone.} Thank you.

1928 The gentleman from Kentucky, Mr. Whitfield.

1929 Mr. {Whitfield.} Thank you very much.

1930 I have a relatively simple question. As you continue to
1931 work and develop the REMS program, and I had mentioned in my
1932 opening statement about NASPER, the national prescription

1933 drug monitoring system. I was curious, have you yourself
1934 worked or your agency worked very much with the DEA or SAMHSA
1935 in implementing this national prescription drug monitoring
1936 system?

1937 Dr. {Sharfstein.} It is an excellent question, and that
1938 system is primarily dedicated to the schedule drugs, and we
1939 have been having some public meetings about how to ensure the
1940 safe use of certain schedule drugs that have very important
1941 medical uses. They are long-acting opiate medicines. You
1942 know, our reach in the REMS program goes really to the
1943 manufacturers and what they can do, but we are very aware
1944 that there are other key players and we have been in
1945 discussions with DEA and others to try to figure out what the
1946 right balance is. We clearly know that patients benefit from
1947 pain relief and it is extremely important. On the other
1948 hand, we don't like to see the fact that patients can die of
1949 unnecessary overdoses or there can be diversion. So it is a
1950 combination, and we have some tools to put on the table to
1951 help with this balance and we are very aware that the other
1952 agencies do and the prescription drug monitoring program is
1953 very much part of the discussion.

1954 Mr. {Whitfield.} Well, I appreciate that, and of
1955 course, REMS is designed to minimize risk for patients and
1956 certainly that is the same goal of NASPER as well to give the

1957 health care providers more information. So I hope that you
1958 all will keep that in your minds as we move forward on trying
1959 to obtain adequate funding to fully implement NASPER.

1960 Dr. {Sharfstein.} Thank you. That is an excellent
1961 point.

1962 Mr. {Pallone.} Dr. Sharfstein, you describe in your
1963 testimony the importance of moving from a reactive approach
1964 to drug safety problems to one that prevents such problems
1965 from occurring in the first place. Obviously prevention is
1966 what we are all about in every aspect of health care. As you
1967 know, the committee worked very closely with the FDA to
1968 develop and pass the Food Safety Enhancement Act this past
1969 summer. We are now waiting and waiting for the Senate to
1970 pass its version, which we hope will be very similar to our
1971 bill. I understand they did pass a bill out of committee.
1972 In my view, one of the most critical components of the food
1973 safety legislation was giving the food industry more
1974 responsibility to ensure the safety of their foods and giving
1975 FDA more authority to ensure the preventive safety controls
1976 are in place, and you mentioned this provision in your
1977 testimony and stated that FDA is taking steps to begin making
1978 this kind of shift within your current authorities. And what
1979 I am trying to understand is whether your current authorities
1980 are adequate to accomplish this.

1981 The Food and Drug Administration Globalization Act of
1982 2009, that is the bill that was developed by Mr. Dingell,
1983 myself, Mr. Stupak and others, and that contains a similar
1984 provision to that in the food safety bill. Specifically,
1985 section 204 of that bill would require drug companies to
1986 develop and implement a quality risk management plan to
1987 incorporate risk identification and control into the
1988 production processes. The plan would, for example, require
1989 the company to assess the competence of potential suppliers
1990 of raw materials or ingredients. It would also require the
1991 company to conduct periodic onsite audits and carefully
1992 monitor the safety of drug ingredients, and this plan would
1993 be available for FDA review during inspections. So what I am
1994 trying to find out is whether you think this approach is
1995 workable and necessary for drugs as we did for foods, and
1996 would it help FDA's efforts to shift to a more preventative-
1997 based drug safety system if the agency had that kind of
1998 enforceable authority?

1999 Dr. {Sharfstein.} Thank you. It is a great question,
2000 and it is in fact true that the same principle that underlies
2001 the food safety bill and a lot of the authorities that is
2002 needed in the medical product arena also. We do think that
2003 new authorities are going to be necessary for FDA to have
2004 confidence in the preventive-oriented approach. Right now,

2005 FDA inspectors are at the border under a legal standard that
2006 we can hold something if there is an appearance of
2007 adulteration, but we can't require, we don't have access,
2008 because we can't require people to have current registration
2009 for, you know, just those facilities that they are making.
2010 We can't require them to present information about their
2011 products meeting key safety standards like having a
2012 preventive plan in place. And so we are not operating under
2013 a paradigm that is really focused on prevention, and we would
2014 like to make that shift and there are definitely elements in
2015 the bill that would accomplish that.

2016 Mr. {Pallone.} I appreciate that. When we did this
2017 Globalization Act, we had the four areas you mentioned,
2018 medical devices, there is also cosmetics, and of course
2019 ultimately we would like to develop legislation or pass
2020 legislation for all four, but we separated out the food
2021 safety because we were making more progress and we felt that
2022 that was the most likely that we could move. But now we want
2023 to move to certainly deal with the drugs and ultimately with
2024 the others as well. So I just ask that you--you know, I know
2025 that you provided a lot of help to us as we developed the
2026 food safety legislation. We would like to have the same
2027 cooperation and help as we move towards drug safety and the
2028 others.

2029 Dr. {Sharfstein.} Well, we really appreciate the
2030 subcommittee's leadership in this area.

2031 Mr. {Pallone.} Thank you.

2032 Mr. Shimkus.

2033 Mr. {Shimkus.} Thank you, Mr. Chairman.

2034 This is a good line of questions and debate and
2035 instruction, so I am glad we are going down this route. I
2036 want to go back. We were involved with the legislation that
2037 is pending over on the Senate side now and so it is a
2038 template for where we want to move but we need to get some
2039 clarification. Does the FDA have tools at its disposal to
2040 have a company take its drug off the market? Do you have the
2041 tools right now?

2042 Dr. {Sharfstein.} There are mechanisms for FDA to have
2043 drugs--you mean if a drug is unsafe?

2044 Mr. {Shimkus.} Right.

2045 Dr. {Sharfstein.} Yes, there is a process for that.

2046 Mr. {Shimkus.} So we do have the tools?

2047 Dr. {Sharfstein.} If there a safety problem with the
2048 medicine so it is no longer safe and effective, yes, there is
2049 a process for that.

2050 Mr. {Shimkus.} And so in the past years you have asked
2051 drug companies to take drugs that are identified as being bad
2052 off the market, have you not?

2053 Dr. {Sharfstein.} Yes.

2054 Mr. {Shimkus.} Has any company ever refused to do so?

2055 Dr. {Sharfstein.} I have to go back, but not that I
2056 know of.

2057 Mr. {Shimkus.} There has been--

2058 Dr. {Sharfstein.} I shouldn't say not that I know of.
2059 I think we would have to get back to you because there may be
2060 some examples of that. But I think that you have to
2061 distinguish between--there are two things. One is the
2062 products and the other is the manufacturing, whether there
2063 are manufacturing issues that could come up as well.

2064 Mr. {Shimkus.} A follow-on question, because we really
2065 want to drill down because we know you have got the ability
2066 to do--we just don't want you to say boom, here is all this
2067 new stuff if there are things that are doing successfully
2068 now. We don't want to create multiple additional new levels
2069 of bureaucracy, we want to build on what is working now. And
2070 so that is why we want to be very specific with our
2071 questions.

2072 Dr. {Sharfstein.} Sure. The one thing I would say is
2073 that it is important that, you know, there may a process to
2074 accomplish something but if that process is so burdensome and
2075 time consuming, it may not be fully protective of public
2076 health. So as we get back on these things to provide

2077 technical assistance, it may be that, yes, there is a process
2078 but we would like a better process, a simpler process that
2079 can be more effective.

2080 Mr. {Shimkus.} In your response to Chairman Dingell,
2081 you stated that you needed additional authority to require
2082 manufacturers to implement quality risk management plans.
2083 And the follow-up question is, do you actually need this
2084 authority or is that something you can do now? Could you
2085 just incorporate this into your good manufacturing practice
2086 regulations?

2087 Dr. {Sharfstein.} We feel like we would need the
2088 authority.

2089 Mr. {Shimkus.} I think we need to talk more.

2090 Dr. {Sharfstein.} I am always happy to talk more, but I
2091 think that we--

2092 Mr. {Shimkus.} That is the whole thing. When we move
2093 legislation, we are going to get more specific. You can help
2094 educate us and we are going to be getting you all the
2095 resources you need.

2096 Dr. {Sharfstein.} They are very different, and it is
2097 similar to the food safety language, because even though
2098 there are food GMPs that we get authority that the food
2099 safety to set preventive standards.

2100 Mr. {Shimkus.} But having been in the room on that, we

2101 struck a good balance, that we didn't go overboard and that
2102 we brought industry at the table so that we didn't duplicate
2103 things.

2104 Dr. {Sharfstein.} I agree.

2105 Mr. {Shimkus.} And that is where we want to be very,
2106 very--because we want to be helpful. We don't want to be
2107 harmful. We don't want to create such--and we talked about
2108 this gap. You talked about really this gap from NIH to FDA,
2109 and you know what ties the companies over to continue to
2110 develop these new drugs, and that is the certainty that if
2111 they are successful, they have a patent and they have a
2112 return on that investment. And of course, we are always
2113 attacking that patent. We do want to attack--I have always
2114 been in the position that when they game the system and
2115 extend that, but I have always supported these folks who are
2116 taking the risk all these years, that gap, the only thing
2117 that keeps them going is that assurance that there is going
2118 to be a return on that investment based upon at least some
2119 period of time where they have exclusive rights to sell that
2120 drug. Isn't that correct?

2121 Dr. {Sharfstein.} I think it is very important that
2122 companies have some protection.

2123 Mr. {Shimkus.} And I am going to end on this as far as
2124 my line. I do appreciate this. As we move forward, I have

2125 great respect for the chairman of this committee. There are
2126 times that we have agreed and we worked well together and
2127 there are times when we fought and we still are friends. And
2128 so I look forward to both times as we move forward.

2129 But I also want to be careful, and I am also on the
2130 high-tech committee here and I understand the benefits of
2131 digital records, and we are always going to fall into this
2132 concern on privacy and the collection of data, and it is a
2133 tough balance. So when we hear words about collecting data,
2134 information on personal records that help us do something, I
2135 think that is going to be easier said than done.

2136 Dr. {Sharfstein.} Right. And just to be clear, what I
2137 was talking about, the sentinel system, there is no personal
2138 data at all that comes to FDA. It is done by the health
2139 systems themselves, the studies.

2140 Mr. {Shimkus.} I am just telling you, most data
2141 breaches are people stealing data and--

2142 Dr. {Sharfstein.} It is a very serious issue--

2143 Mr. {Shimkus.} --selling it with flash drives and
2144 stuff, so thank you, Mr. Chairman.

2145 Mr. {Pallone.} Thank you.

2146 The gentleman from Texas, Mr. Burgess.

2147 Dr. {Burgess.} Thank you, Mr. Chairman. This is a good
2148 hearing and a good discussion. I hope we actually have an

2149 opportunity to have a similar discussion regarding medical
2150 devices at some point in the future because they deserve no
2151 less of our scrutiny.

2152 Dr. Sharfstein, I wasn't in the room when Mr. Dingell
2153 was asking questions, but some of them have been sort of
2154 reintroduced now by Mr. Shimkus. On the border authority--we
2155 all remember the story of the tomatoes a couple years ago and
2156 the unfortunate discovery at 5:00 on a Friday afternoon that
2157 it was Mexican peppers that were causing salmonella outbreaks
2158 that had riveted the news shows for the whole summer, but the
2159 FDA lacked the authority to actually stop the importation at
2160 that point. Have you identified the authority that you need
2161 there to keep this occurrence from happening in the future?
2162 Are there things you need from us to be able to have that
2163 authority if you have identified the authority and you lack
2164 it?

2165 Dr. {Sharfstein.} With respect to food particularly?

2166 Dr. {Burgess.} Particularly with respect to food, but
2167 we are going to get into some of the pharmaceuticals in a
2168 minute.

2169 Dr. {Sharfstein.} There is no question we need more
2170 authority because we want to shift to prevention. We need to
2171 be able to see--

2172 Dr. {Burgess.} So can you identify for us specifically

2173 what that authority is that you need?

2174 Dr. {Sharfstein.} Well, I think that that is where we
2175 worked with the committee on the legislation that is
2176 hopefully going to pass, is going to address that gap. There
2177 are sections that relate to what is required to import food.

2178 Dr. {Burgess.} And is the language in the bill that Mr.
2179 Dingell said was languishing safely in the Senate, is that
2180 language enough? Is it going to provide you enough of the
2181 authority of what you need to have?

2182 Dr. {Sharfstein.} Yes, we support that legislation
2183 because it is going to be an enormous step forward for how we
2184 can assure the safety of imported food and domestic food.

2185 Dr. {Burgess.} So any changes that occur over the other
2186 body then would need to be scrutinized pretty carefully to
2187 make certain that they didn't strip away the authority that
2188 you have identified that you will need?

2189 Dr. {Sharfstein.} Well, there is no question. All
2190 these provisions are extremely important, and it is very
2191 important that, you know, we look at all of them as they get
2192 modified in the legislative process.

2193 Dr. {Burgess.} Another story that really just riveted
2194 the headlines 2 years ago was the Chinese heparin story.
2195 What has happened? We had a hearing I think in April or May
2196 of 2008. It hasn't really been in the news stories. What is

2197 happening in that investigation now? Is there anything new
2198 that has come up from your looking into the manufacturer of
2199 the isolation of heparin overseas? Are we still importing
2200 the active pharmaceutical ingredient from overseas? Where
2201 are we with that?

2202 Dr. {Sharfstein.} There is certainly a huge level of
2203 import from China for heparin. What has really happened
2204 since that time is after the source of the problem was
2205 identified, there was a new standard written for heparin that
2206 has been adopted by companies and regulators around the
2207 world. It has been incorporated into the USP, which is sort
2208 of the standard-setting body, so that now--previously it
2209 wouldn't have caught the problem, oversulfated chondroitin
2210 sulfate.

2211 Dr. {Burgess.} Right. It was a clever contaminant to
2212 hide behind.

2213 Dr. {Sharfstein.} Right. Much cheaper than heparin,
2214 but evaded the tests, went below the radar. FDA played a
2215 critical role in identifying how you can find that
2216 contaminant, demonstrated that when you add that contaminant
2217 to heparin you get the problem in animals, and then set up a
2218 standard that has been incorporated around the world and we
2219 haven't seen those kinds of reports that we were getting
2220 since that time.

2221 Dr. {Burgess.} Well, now, heparin wouldn't truly be
2222 regarded as a biologic but there has been some question in
2223 this committee about how your agency would administer the
2224 follow-on biologic approval process. So in light of
2225 everything, do you feel like you have an adequate ability to
2226 safely and properly monitor and implement the approval
2227 process for follow-on biologics or what are referred to as
2228 follow-on biologics?

2229 Dr. {Sharfstein.} From the perspective of the supply
2230 chain, I think for all, you know, medications and biologics,
2231 we would like to see strengthening of the supply chain
2232 including the things that are there now but--

2233 Dr. {Burgess.} Right. The supply chain in this
2234 instance just showed the weakness, though, of the process
2235 used to identify contaminants. In approving follow-up
2236 biologics, I mean, it underscores how important the safety
2237 aspect is. Do you feel that with what you have available to
2238 monitor and screen the follow-on biologics in that process?
2239 We have had that debate somewhat in this committee. We have
2240 never had you guys in to ask you about that. We have had the
2241 Federal Trade Commission in, which I never understood. So
2242 now that I have got you here, what about the discussion on
2243 follow-on biologics?

2244 Dr. {Sharfstein.} I think that the follow-on biologics

2245 sort of supply chain issues are the same as for the regular.
2246 In some cases, they are the same companies making them. So--

2247 Dr. {Burgess.} No, outside the supply chain, just the
2248 overall safety of follow-on biologics.

2249 Dr. {Sharfstein.} That is something that is very
2250 important to base on individual products and the best science
2251 available, and FDA believes that with adequate resources and
2252 the right--

2253 Dr. {Burgess.} You said you had all the money you
2254 needed, remember, the previous question.

2255 Dr. {Sharfstein.} I don't--we could check the
2256 transcript on that one. I think that what we would like is
2257 the flexibility to have standards that are based on the best
2258 available science for particular products, and with that in
2259 place, we would explain how we are setting up those standards
2260 and be able to do it in a way that could get products on the
2261 market that could be enormously important to the public.

2262 Dr. {Burgess.} So where are we in that process now? We
2263 had some language in the bill that we passed, and goodness
2264 knows what is going to happen to that bill, but are you all
2265 waiting for Congress to do something?

2266 Dr. {Sharfstein.} I think we are certainly waiting to
2267 see what happens with health care reform because there is
2268 some language in there, but I think that we would also look

2269 to the authority we have to decide whether it would make
2270 sense for us to move forward without new language, but that
2271 is not something we have reached final decision on.

2272 Dr. {Burgess.} Is there a product out there right now
2273 that is awaiting your ability to be able to offer those
2274 approvals or direct further study?

2275 Dr. {Sharfstein.} There is certainly a lot of interest
2276 in the industry but I don't know if I could point to a
2277 particular product.

2278 Mr. {Pallone.} Okay.

2279 Dr. {Burgess.} Thank you, Mr. Chairman.

2280 Mr. {Pallone.} You are welcome.

2281 Let me thank Dr. Sharfstein. Thanks a lot. This was
2282 very helpful, and we appreciate it, and obviously we would
2283 like to move forward on the drug safety issue as we did on
2284 food safety. You actually said that you are going to follow
2285 up with certain written responses in some cases, so I would
2286 appreciate those as soon as possible, and members can submit
2287 additional questions for the record as well. I am going to
2288 try to get those submitted to the clerk within the next 10
2289 days, so I would ask members if they want to submit written
2290 questions, to give them to us within the next 10 days, and
2291 then after that we would ask you to get back to us as quickly
2292 as possible.

2293 Dr. {Sharfstein.} Okay. Great.

2294 Mr. {Pallone.} Thank you again, and without objection,

2295 the hearing of the subcommittee is adjourned.

2296 [Whereupon, at 4:22 p.m., the Subcommittee was

2297 adjourned.]