The public radio show about law and American life

Justice Talking
Radio Transcript

Should Dying Patients Have a Right to Use Experimental Drugs?—Air Date: 4/16/07

Should patients who are seriously ill or dying have the legal right to try drugs that haven't yet been approved by the U.S. Food and Drug Administration? Last December the FDA proposed new guidelines that would allow access to experimental treatments on a case-by-case basis. But some health care professionals fear that access to drugs that are not yet proven safe is dangerous, unethical and disastrous for the drug approval process. On this edition of Justice Talking we ask who should have the right to use experimental drugs.

MARGOT ADLER: This is Justice Talking, the public radio show about law and American life. I'm Margot Adler. On today's show we're talking about experimental drugs and whether someone with a terminal illness should be able to get access to a new drug even if it hasn't been approved by the Food and Drug Administration. The FDA has a strict protocol that keeps ineffective and potentially dangerous products from being prescribed. But for dying patients who have exhausted all other options, that process can seem like bureaucratic red tape and can restrict them from a treatment that could potentially save their lives. We'll look at this battle over experimental drugs from all sides. We'll hear from doctors who are faced with a question of whether to encourage their patients to pursue untested drugs, and we'll see how the FDA is revamping its regulations for approving drugs in the wake of a recent lawsuit on this issue. We'll also talk with the father whose daughter died of cancer who says her life might have been extended if she'd had access to an experimental cancer drug. Some say this battle over a patient's right to experimental drugs could be the next big civil liberties battle in America. It may be hard to understand why someone would want to take the risk and use a drug that hasn't been approved by the FDA, but when a doctor tells you that there is no treatment for your condition and that the disease is terminal, the desire to live may outweigh the risks of an untested drug.

When she was 48, Tania Stutman was diagnosed with GIST, a gastrointestinal stromal tumor, a rare form of cancer that her doctors told her was untreatable. When she got the diagnosis, her doctor said she would probably just live through the remainder of the year. Her gynecologist found the tumor during a routine annual exam. Tania opted to have a hysterectomy to take care of the problem. It was during that operation that her doctor found that the tumor was located in her intestines, not on her ovary, as the doctor had thought.

TANIA STUTMAN: To the surgeon's dismay, when he did the total hysterectomy he realized that actually there was nothing on the ovary but something was on the small bowel, which was a tumor. And he found himself having to do a consultation on the phone with another surgeon to decide what needed to be actually done.

MARGOT ADLER: After the surgery and a biopsy, Tania was told her tumor was benign. Then the doctor returned. His original diagnosis was wrong.

TANIA STUTMAN: The doctor walked in and told us that it was malignant. It was cancer. And then, of course, he added that was a rare form of cancer. And the later time, of course, we were told that actually I probably most likely will only have that year to live. I basically was told to go home and get my life in order.

MARGOT ADLER: She and her husband were shocked by the news. It seemed there was nothing they could do given that her type of cancer was so rare.

TANIA STUTMAN: Unfortunately, nine years ago there were just not specialists. There just was nothing really for known cancer, you know, so it was very, very difficult finding doctors that have any knowledge about this particular cancer. It was unbelievable. It was very hard to find.

MARGOT ADLER: Doctors told her the cancer was untreatable. That neither radiation nor chemotherapy would help. Tania says she felt like she had no options.

TANIA STUTMAN: I was desperate. You know, it's a strange thing that most of us don't really deal with our own mortality on a daily basis and so something like this happens and then you realize that you are facing your own mortality. And at that time I, you know, would've given anything to be able to go into, for instance, a clinical trial, as I would've done, you know, for two reasons. Number one, at that point knowing that I wasn't given any options, I was willing to take a chance in going to a clinical trial with an experimental drug, and take my chance because I had nothing to lose but everything to gain.

MARGOT ADLER: Tania did lots of research on her disease and learned about a clinical trial for a new cancer drug. By that time her cancer had spread to her liver. She was accepted into the trial and three years after her diagnosis she began taking Gleevec, a drug developed by Novartis. She credits the drug and the clinical trial with keeping her alive for the last six years.

TANIA STUTMAN: I entered the clinical trials because I had--there were no other options available to me. And I wanted to take the chance in entering the clinical trial so that maybe it would give me a new lease on life. And the other thing about it is that even if, for instance, it

wouldn't have helped me but at least through the clinical trial it would have helped others. And to learn more about it can help, you know, others to benefit from this trial.

MARGOT ADLER: In the nine years since her diagnosis she has become an advocate for people who have this form of cancer and thinks that experimental drugs must be made available to people who have no other options.

TANIA STUTMAN: But I think in today's world we all basically have known someone that we love that has lost the battle to cancer. We have known a friend that is going maybe through process of dealing with cancer, and it's very devastating. And no one can imagine what someone has to do and is going through with it. We need to be a little bit more open-minded about it because we all want to live. We all want to have a life. We all want to share our life with our loved ones. And we all need to do what it takes to stay alive.

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MARGOT ADLER: That was Tania Stutman, a New York woman who has been living with cancer for the last nine years.

Doctors are the gatekeepers between patients and clinical trials for drugs that could potentially treat their diseases. To find out how clinical trials work and to find out about how pharmaceutical drugs are regulated in the U.S., I talked with Dr. Brian Strom. He's a professor at the University of Pennsylvania School of Medicine in Philadelphia. He is also chair of the department of statistics and epidemiology there. Welcome to Justice Talking.

BRIAN STROM: My pleasure.

MARGOT ADLER: Brian, how did the Food and Drug Administration begin regulating drugs?

BRIAN STROM: The Food and Drug Administration has gathered increasing powers gradually over the years. It began in 1906 with the Food, Drug and Cosmetic Act. Then it got substantially additional power after an epidemic of Elixir of Sulfanilamide poisoning. This is a sulfa antibiotic that instead of having alcohol in it to dissolve it the company by mistake put in diethylene glycol, which is antifreeze.

MARGOT ADLER: And I gather that the thalidomide situation later actually had a big impact?

BRIAN STROM: Correct. Thalidomide in the early 1960's led to the FDA's power to regulate about efficacy. Thalidomide was a sedative, hypnotic drug thought to be very safe. It's actually on the market in the U.S. now again. But it was marketed for wide safety including safe for use in pregnancy. It was an incredibly effective what's called a teratogenic agent that is a cause of birth defects, terrible birth defects where kids were born without limbs or with flippers instead of limbs. The Kefauver-Harris amendments were passed. The FDA was given a lot more power in order to regulate drugs before they are marketed, and it's the first time drugs had to be proven to be effective before they were allowed to be marketed.

MARGOT ADLER: How does the current regulation process work?

BRIAN STROM: Currently there are three formal phases of testing and then a fourth informal phase. The three formal phases--Phase One, Two, and Three--all come after animal testing. Phase One testing is normally in small numbers of human volunteers, often medical students, who get the drug to look for major safety issues in very small numbers of people. Phase Two testing is usually the first time patients are exposed in order to see what dose of the drug might work. And then Phase Three testing formally tests whether or not the drug at the does that it's going to be marketed in indeed works for that purpose. Throughout Phases One to Three, generally between 500 to 3,000 patients are exposed. If efficacy can be proven in smaller numbers then Phase Three is prolonged in order to gather on the order of 500 to 3,000 patients.

MARGOT ADLER: Now I know that a lot of drugs never make it to market. How many drugs enter the process but aren't ultimately approved?

BRIAN STROM: There are thousands and thousands of chemicals that are tested for every drug that ends up making it to market. Probably roughly ten drugs enter humans for every drug that gets to the market.

MARGOT ADLER: And in general how long does the process take from the beginning for a drug to be approved?

BRIAN STROM: As a rough ballpark, from the time a chemical first enters testing until it's approved is on the rough order of a decade.

MARGOT ADLER: How much does it generally cost for a drug to go through this entire approval process?

BRIAN STROM: A commonly quoted figure about costs of going through the process is about $800 million per drug. You have to look at that carefully. It's not that any one drug cost $800 million. It's if you take the entire drug development process for all possible drugs and divide it by the very few successes, it ends up being $800 million.

MARGOT ADLER: That of course makes at least the layperson think that it's not in the interest of many drug companies to do drugs that aren't going to really get a lot of money back.

BRIAN STROM: You're absolutely correct. The companies clearly want large-selling drugs in order to be able to make back all of that money. They also want that money as soon as possible. They also want to get the drug on the market as soon as possible because the patent expiration ends at a fixed date. They make their money only between the time of drug approval and that patent expiration when generics then come on the market.

MARGOT ADLER: Let's talk for a minute about clinical trials. First, how do they work?

BRIAN STROM: The typical clinical trial chooses a very artificial group of people who are allowed to be in the trial for various reasons. And then by chance randomly assigns people to

one drug or a placebo or to that study drug and an alternative drug. Usually it's a placebo, however.

MARGOT ADLER: We just heard from a cancer patient who's involved in a clinical trial of a drug that was not designed to treat her form of cancer but she's in it and has had success for over five years. What do you have to say to a patient whose life is on the line when access to an experimental drug through a clinical trial could put off death for a number of years?

BRIAN STROM: If access to an experimental drug could put off death for a few years it's worth taking the chance if other things have already been tried, absolutely. You have to keep in mind that access to that experimental drug, if it means delaying access to conventional therapy, could end up shortening her life.

MARGOT ADLER: Dr. Brian Strom is a professor at the University of Pennsylvania School of Medicine. He is chair of the Department of Statistics and Epidemiology. Thanks for talking with me.

BRIAN STROM: Sure, my pleasure.

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MARGOT ADLER: Coming up on Justice Talking we'll debate whether seriously ill patients should be allowed access to drugs that haven't been approved by the FDA.

UNIDENTIFIED MALE: The big difference is that these people have run out of options. Their only option is death. Now whose decision should this be?

MARGOT ADLER: Should cancer patients and other people who have been told they will die be allowed access to experimental drugs? Stay with us.

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MARGOT ADLER: This is Justice Talking. I'm Margot Adler. We're talking about whether people diagnosed with life-threatening diseases should have access to drugs that haven't yet been approved by the FDA. There are many people who have been diagnosed with untreatable diseases like cancer. Their doctors have told them that there are no drugs to cure them and that the illness will eventually kill them. Some say that they should be able to get access to drugs that may or may not keep their illness and death at bay.

To talk about what the policy should be on getting access to experimental drugs are Frank Burroughs and Ellen Stovall. Frank Burroughs is the founder and president of the Abigail Alliance, a nonprofit organization that advocates for patient's rights to experimental drugs. His organization was part of a lawsuit in the Washington, D.C. Circuit Court to get access to these drugs. Ellen Stovall is the president and CEO of the National Coalition for Cancer Survivorship. It's an organization of cancer survivors that promotes quality cancer care. Welcome both of you to Justice Talking.

FRANK BURROUGHS: Thank you.

ELLEN STOVALL: Thank you.

MARGOT ADLER: Frank, you head up the Abigail Alliance. Tell us how the organization got started.

FRANK BURROUGHS: The way the Abigail Alliance came about was with my daughter's struggle to get an investigational drug, developmental drug, for her head and neck cancer. And we couldn't get it. She didn't qualify for the strict protocols of the clinical trials. And shortly after she left this earth in 2001 I literally had an epiphany. Then I said to myself, why should I stop now? There are other people out there as precious as Abigail.

MARGOT ADLER: Ellen, tell us what your organization, the National Coalition for Cancer Survivorship, does.

ELLEN STOVALL: Well our organization is principally made up of--at least 50 percent of us must have a personal experience of cancer ourselves, therefore being diagnosed. I'm a 35-year survivor of two bouts with cancer. And our organization's mission is to advocate for quality cancer care for all Americans and we're about 20 years old. We're really founded out of a grassroots organization that was providing support to individuals in the state of New Mexico in 1986. But we are nationally located now in Washington, D.C. to advocate for these issues on behalf of people with cancer and their families.

MARGOT ADLER: Frank, your organization brought a lawsuit against the FDA. Why?

FRANK BURROUGHS: Well, the first thing that we did is we tried to get some dialog going with the FDA and in the patient advocacy community, especially with some of the large, established patient-advocacy communities, about coming up with ways to get better access to investigational drugs that show early efficacy and they're no known safety issues at the time. Everything just fell on deaf ears. We got nowhere. So the first thing we did was we filed a citizen's petition and then we had no response to that and so we filed a lawsuit.

MARGOT ADLER: Let's say I have a terminal illness and I've been given six months to live. Ellen, why shouldn't I have the right to get experimental drugs if my doctor determines it's the best course for me?

ELLEN STOVALL: I'm not saying you shouldn't have that right. In fact you have every right to pursue that avenue and I would expect that people would and might want to take advantage of the programs that exist today for you to access those therapies. We believe that the FDA, while not perfect--no agency is, has made many, many efforts outside of their mandate to do so. Their mandate is not to afford people access to individual drugs. But they have established mechanisms, the two most notable being one that's referred to as compassionate or emergency use--

MARGOT ADLER: And explain what that is.

ELLEN STOVALL: Well, that's when it's determined by a physician and a patient that there is no existing future treatments that could be considered efficacious. Either no clinical trial or no existing therapy for that person--

MARGOT ADLER: And that's for an individual, correct?

ELLEN STOVALL: That is for an individual. And so individual access to these unapproved therapies can be pursued through these mechanisms.

MARGOT ADLER: Frank, clinical trials happen for every drug that the FDA approves. A lot of people enroll in clinical trials because it's the only way that they can get access to certain drugs. If someone can go to their doctor and get these drugs, won't that imperil the science of drug testing?

FRANK BURROUGHS: Absolutely not. Everything that the Abigail Alliance has been saying, what's in the access act, which is a bill in Congress that's a direct result of the efforts of the Abigail Alliance and our allies, clearly states that a patient would have to first try to get into a clinical trial, and if they couldn't, then could gain access to these investigational drugs.

MARGOT ADLER: Isn't it a big risk for doctors to prescribe experimental drugs? After all, you know, they and the drug companies could be held liable if the drug was found to increase mortality and suffering.

FRANK BURROUGHS: Well, first of all, we strongly feel that decisions on drugs should be between a patient in consultation with their doctor. The other thing is we're talking again about drugs that are being tested in clinical trials, proven safe enough to continue testing in clinical trials, and that show early efficacy and no known serious safety issues. The liability issue is a sticky wicket. It's addressed to some degree in the access act, but it's something that industry and the public and government needs to address because there's extreme lawsuits. And there needs to be something that's fair to all patients that are harmed without these ridiculously high liability settlements.

MARGOT ADLER: Ellen, what do you see is the effect on doctors of all this?

ELLEN STOVALL: I, you know, I think there are numerous issues. One that hasn't been mentioned is how this would effect reimbursement both for the patient and the physician. Health care plans, Medicare, are loathe to begin discussions with anyone until the FDA has approved these drugs for use. We worked for years and years and years in cancer advocacy to get coverage for the off-label use of cancer drugs that have shown to be effective in multiple cancers. People assume there are a lot of patients enrolled in Phase One trials, and even Phase Two trials for that matter, with very, very small numbers of people, and the numbers there are just not necessarily sufficient to enable investigators, physicians, clinical researchers, anyone looking at these drugs, to identify their serious adverse effects. And we just don't want to see that happen. Patients can really be harmed by these drugs.

MARGOT ADLER: Frank, do you want to respond to that?

FRANK BURROUGHS: Yes, first of all, I go back to what I was saying: We feel that the decision should be between a patient in consultation with their doctor and not from the paternalistic FDA or others who are deciding who gets the drugs and who doesn't. But again, I want to stress that we're talking about drugs that show early safety and efficacy in the clinical trial process, that have been shown to be safe enough for larger populations of people. And these people, the big difference is that these people have run out of options. Their only option is death. Now whose decision should this be? I tell you, I'm not talking--I'm talking from having been in the trenches with a patient and now with hundreds of patients since I started the Abigail Alliance. They strongly feel that it should be their decision.

MARGOT ADLER: Ellen, but if, let's say, someone has only six months to live and they've been told that they're terminally ill, shouldn't issues like safety and toxicity and efficacy be way down on the list compared to another kind of person?

ELLEN STOVALL: I would say that when people have run out of treatment options that we know to be accessible to them and that when they have tried every existing way to get access to these therapies, our experience tell us that one of the most beneficent things that we can be doing as a society is having a dialogue with our loved ones, with our families, about how we want our lives to end, because that inevitability is there for all of us. And in the absence of that dialogue, some very bad public policies could be created that could really harm the public interest. It's not just us as individuals, but my organization is dedicated to public policies in the public interest. I can't say what I would do if faced with a decision of a child that was dying of cancer, because I have not had the misfortune of--that Frank has had. And I can't even imagine; it's unthinkable to me. But what we would do as individuals must be preserved in a place that's different from making public policy.

MARGOT ADLER: I'd like to ask both of you: Who should pay for these experimental drugs? If insurance companies won't cover them since they aren't approved, won't only the wealthiest have access to them? I'll start with you, Frank.

FRANK BURROUGHS: If that does become the case, if there isn't insurance coverage, then only some people obviously would get the drug. And the analogy I use is the Titanic. The Titanic is sinking. You don't have enough lifeboats. You can only save the women and children. Does everybody go down with the ship? I don't think so. The other point is that the pharmaceutical industry contributes literally billions of dollars just cancer drugs gives them to people free or at discount for people who can't afford them. I think they would continue to do this if we had this earlier access.

MARGOT ADLER: Ellen, who do you think should pay for these drugs?

ELLEN STOVALL: You know, I'd like to answer the question a little differently because I, you know, paying for the drug to me is the least important issue being talked about here. I really feel that there's an ethical issue at stake. And I think it gets to the whole way we do drug

development and we design clinical trials. And we promote access to people who need access when they've exhausted all options. I worry about the haves and the have-nots and it's not about wealthy versus not wealthy. I worry it's about a congressman calling up and saying: I want a constituent to have access to this drug or others. Some companies refuse to even engage in discussions about expanding access. They'll only consider a lottery for their products; these have created a lot of concern on the part of the public as well. I just don't think we're in that much disagreement. I think that we are in disagreement with how to solve the problem but I do see existing remedies for it that I think would serve the public interest better.

MARGOT ADLER: Ellen Stovall is the president and CEO of the National Coalition for Cancer Survivorship, an organization of cancer survivors that promotes quality cancer care. Frank Burroughs is the founder and president of the Abigail Alliance, an organization that advocates for patient's rights to experimental drugs. Thank you both for coming on Justice Talking.

ELLEN STOVALL: Thank you for having us.

FRANK BURROUGHS: Thank you.

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MARGOT ADLER: Cancer-fighting drugs and other prescription drugs developed to fight serious illnesses go through rigorous research and development before ever making it to the mass market. It is in clinical trials with relatively small populations of patients where these drugs are really tested. To talk about increasing patient access to pharmaceutical drugs and what that would mean for the pharmaceutical industry is Alan Goldhammer. He is the deputy vice president for regulatory affairs at the Pharmaceutical Research and Manufacturers of America, PhRMA. Welcome Alan.

ALAN GOLDHAMMER: Well, thank you for having me.

MARGOT ADLER: Tell us where the pharmaceutical industry stands on increasing access to experimental drugs for the seriously ill.

ALAN GOLDHAMMER: Well, we try to make drugs available as early in the process as can be done. There are some constraints on that, however, that the listeners need to be aware of. Companies don't manufacture large quantities of clinical trial material. So there are going to be limits as to how much material is going to be available. And secondly, and most importantly, we don't want to compromise the clinical development process.

MARGOT ADLER: So what are the biggest problems for the pharmaceutical industry if patients gain the right to access experimental drugs before they go through all the stages of a clinical trial?

ALAN GOLDHAMMER: Well there are a couple of major ones, and I think the primary one is: The physician that is taking care of these patients, have they been trained sufficiently in the administration and care of somebody who is on an experimental drug? This is one of the reasons

why pharmaceutical companies very carefully screen clinical investigators to assure that the patients are being well cared for while they're in a clinical trial. There are, you know, obviously also major ethical issues when one is administering an experimental drug; informed consent is required, the clinical protocols need to be thoroughly reviewed and approved by institutional review boards and so forth.

MARGOT ADLER: If the Abigail Alliance wins their court case, is the industry prepared to meet the demand of patients seeking access?

ALAN GOLDHAMMER: I think that's a difficult question to answer because that is clearly going to be a question that individual companies are going to need to answer for themselves. Because they are the ones that are manufacturing the clinical trial material and it's not an inexpensive proposal for many of these new drugs to manufacture material up, you know, to larger quantities than might be used in a clinical trial.

MARGOT ADLER: What about liability for a pharmaceutical company? Isn't that a huge concern for the industry even with FDA-approved drugs?

ALAN GOLDHAMMER: Well, there's always going to be liability, whether the drug is approved or not approved. I think the big difference in clinical trials is that drugs are administered, you know, only after a number of steps have been taken, you know, protocol has been carefully studied and reviewed by the Food and Drug Administration. It has then been further reviewed by the institutional review board for where the clinical trial is taking place. And then all of these drugs are administered under informed consent.

MARGOT ADLER: Alan, who should pay for these drugs? If insurance companies won't cover them because they're not yet approved, who should?

ALAN GOLDHAMMER: Well the companies can recover certain costs of clinical development.

MARGOT ADLER: Are you talking about insurance companies or the companies that manufacture the drugs?

ALAN GOLDHAMMER: The companies that manufacture the drug. They can charge only to a certain amount to recoup costs. They cannot charge to earn a profit on an experimental drug.

MARGOT ADLER: Alan, I'm sure lobbyists for the pharmaceutical industry are spending millions of dollars to affect the outcome of this national debate--yes/no?

ALAN GOLDHAMMER: No, I don't think we have. I mean we've been pretty outspoken that we're happy to talk about all kinds of new and different approaches to help those who are seriously ill. Companies have made drugs available on a compassionate use in the past and will continue to do so in the future. One of the things that concerns us very much is that there have been proposals to make drugs available very early on in development, even before the best dose of the drug is even known. We don't think that's wise policy. And the other thing that I think concerns us an awful lot is that while we are very sympathetic to patients who find themselves in

suffering from one of these diseases, you know, we want to insure that as these programs go on that patients don't harbor a false hope that by getting into, you know, an experimental protocol that this is going to provide an effective treatment for what they're suffering from. Because I think we all need to recognize that one of the things about experimental drugs is they are just that. They are experimental. We don't know all of the safety issues nor do we know whether the drug is even going to work.

MARGOT ADLER: Alan Goldhammer is the deputy vice president for regulatory affairs at the Pharmaceutical Research and Manufacturers of America, PhRMA. Thank you so much for coming on our show.

ALAN GOLDHAMMER: Well thank you for having me.

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MARGOT ADLER: Coming up on Justice Talking, we'll hear from a cancer doctor who says that giving patients access to untested experimental drugs may not always be ethical.

UNIDENTIFIED MALE: What cancer patients really need are new drugs that are proven to fight cancer and cure cancer, not access to an array of unproven chemicals that provide false hope.

MARGOT ADLER: Should Americans have the constitutional right to experimental drugs? Stay with us.

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MARGOT ADLER: This is Justice Talking, where we make the connection between law and American life. I'm Margot Adler. We're talking about whether seriously ill people--people who have been basically told that they will die of an untreatable disease--should have access to pharmaceutical drugs that have not yet been approved by the FDA. The Food and Drug Administration is the government agency that regulates all pharmaceutical drugs in the U.S. Recently the agency has made changes in an attempt to make it easier for patients to get access to experimental drugs.

To talk with us about this is Dr. Rachel Behrman. She's the deputy director in the Office of Medical Policy at the Food and Drug Administration. Welcome to Justice Talking.

RACHEL BEHRMAN: Thank you.

MARGOT ADLER: Compare what a patient's options are right now for getting experimental drugs with what would happen under the new proposal.

RACHEL BEHRMAN: Truthfully, with a practitioner who is very savvy about how to navigate the Food and Drug Administration, about how to navigate the pharmaceutical industry, not that much would change. But for a practitioner who really, if you will, is a novice at this process, it

should be much easier to figure out what are the options for the patient and how to go about doing it and getting the access that they feel this patient needs.

MARGOT ADLER: Give us a brief history of how experimental drugs have been made available over the last 30 years.

RACHEL BEHRMAN: It started primarily in the '70s in the cardiovascular area, where patients who had no alternative therapies began to receive access to different drugs, such as cardio-selective beta blockers. It didn't become very well discussed or recognized until the '80s, until the explosion of the HIV epidemic, when patients increasingly who were without therapies recognized and demanded access to drugs that were under investigation. And it wasn't until 1987--although many, many thousands of patients had received access before that time--it wasn't until 1987 that our regulations, FDA regulations, formally recognized two avenues for access. First, for a very seriously ill patient for whom there was no time for the physician who was caring for them to send paperwork in, and what we call the "treatment I and D," which is large-scale access for seriously ill patients or patients with a life-threatening disease. And that's really what a treatment I and D is, in a very large-scale but very near the end of the development of drugs, that is, very near the end of when the drug is in its clinical trial process.

MARGOT ADLER: The FDA has approved fewer drugs in the last two years than it has in the past. Why is this?

RACHEL BEHRMAN: The first answer is that we've had fewer applications, but the question is why that is, and why there are fewer new compounds in the pipeline or why the compounds, even given if there has been an increased investment, increased spending, why more compounds aren't making it to the market. And that has to do in part with that we're smarter about identifying safety problems earlier and in part has to do with the science behind drug development--underpinning drug development has not kept pace, and that is something that we're currently working on.

MARGOT ADLER: Yeah, what are some of the concerns that the FDA has if various things happen, whether in the courts or in Congress, that basically allow patients easier access to experimental drugs at earlier stages?

RACHEL BEHRMAN: It's important to recognize that the central thing we're striving to do with these proposed regulations is balance the tension between three sometimes competing interests. There's the interest of the patient, the need for access to therapy when they have no options. And there's us as the agency, there's our obligation to protect that patient from unnecessary unjustified risks and that could include fraud, and also to protect society from the lack of information because the best, most effective means of treatment is the marketed drug, one that we understand, we know how to use optimally, safely, and effectively.

MARGOT ADLER: Dr. Rachel Behrman is the deputy director in the Office of Medical Policy at the Food and Drug Administration. Thank you so much for talking with me.

RACHEL BEHRMAN: You're welcome.

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MARGOT ADLER: Earlier in the show we heard from Frank Burroughs, the founder and president of the Abigail Alliance, whose daughter died from head and neck cancer. His organization sued the FDA to get patients easier access to drugs going through the approval process. Scott Ballenger is a lawyer who represented the Abigail Alliance in that lawsuit against the FDA. He won the case in the D.C. Circuit Court of Appeals. He's with the firm of Latham & Watkins in Washington, D.C. Welcome to Justice Talking.

SCOTT BALLENGER: Thank you.

MARGOT ADLER: Tell us about the case you argued, Abigail Alliance vs. von Eschenbach.

SCOTT BALLENGER: Well, it's a fundamental rights, constitutional privacy case in the same tradition as the contraception cases and a series of fundamental rights cases the court has decided for the last 100 years, really. Our claim is that patients who are terminally ill and have exhausted all of the approved treatment options have a fundamental right to decide for themselves whether to take the risks associated with treatment with investigational drugs. And we're talking here about drugs that the FDA itself has cleared for substantial human testing, drugs that are currently in Phase Two human clinical trials. And my clients are patients who for one reason or another have tried to get into the trials but simply can't, usually just because the trials are frequently too small to accommodate all of the people who desperately need access to the drug, or because sometimes the trials come with restrictive criteria for eligibility, like that you can't have been treated aggressively with some other drug in the past.

MARGOT ADLER: As I understand it, most privacy law is really a negative, the right to be free from, for example, invasive treatment at the end of life. So I've never heard that privacy really works as far as the right to gain something new.

SCOTT BALLENGER: Well, this is actually a negative right exactly like all of the others you're talking about. No one is claiming a right to affirmative government assistance of any kind. All that we're asking is that the FDA get out of my client's way and allow them to use their own private resources to fight for their own lives in life-threatening circumstances.

MARGOT ADLER: There was a case in 1979 over the drug Laetrile, which some patients believed was a cure for cancer, but which hadn't been approved by the FDA. Patients sued and lost in the Supreme Court. Why is your case any different?

SCOTT BALLENGER: Well, the fundamental difference between the Rutherford case and Laetrile and what we're asking for is the patients in the Rutherford case were asking to take something that had not been tested at all, had not been approved by the FDA for human clinical testing at all. And they were proposing to forego conventional therapy in order to do it. And in that context the Supreme Court said that there is, even for terminally ill patients, there is an important relationship between the efficacy of a drug and its safety, because if you are foregoing proven conventional treatment in order to take something that is untested and unproven then

doing that may affirmatively harm you in the sense that you forego treatment that might help you. We are in this lawsuit talking only about people who have exhausted all of the approved treatment alternatives, so there's nothing in the way of conventional therapy that they're passing up. And we're only talking about drugs that, unlike Laetrile, the FDA itself concedes are safe and promising enough to be tested in substantial numbers of human beings. Phase Two trials usually involve somewhere between 200 and 1,000 people, and the FDA recognizes in the case of these drugs that there is enough evidence of safety and enough evidence of potential efficacy for those trials to be ethical. All that we're saying is that the FDA should give the same freedom to patients who are unable to gain a spot in the trial, that it is simultaneously given to the patients who aren't lucky enough to win those few coveted spots in the clinical trial.

MARGOT ADLER: Where does your case stand now?

SCOTT BALLENGER: Well, the D.C. Circuit Court of Appeals ruled for us in a three-judge panel. The way that federal court of appeals cases are usually decided is that the case is assigned to a three-judge panel of judges. The D.C. Circuit Court of Appeals as a whole, though, is 10 judges, and they have granted re-hearing "in bank," which means a re-hearing in front of the full panel of 10. So we had a couple of weeks ago re-argument of the case in front of the full panel of 10 judges and they will re-decide the case sometime this spring.

MARGOT ADLER: And what has the main argument by the FDA been?

SCOTT BALLENGER: Well, the FDA's main argument is that their policies in this area should be subjected to nothing other than basic rationality scrutiny.

MARGOT ADLER: What does that mean?

SCOTT BALLENGER: Well the basic divide in constitutional law is that if a government policy implicates fundamental rights it has to be narrowly tailored to a compelling state interest. If it doesn't implicate fundamental rights then it only has to be rational. And the FDA's position in the case has been that no fundamental rights are implicated in this context and therefore all they have to show is basic rationality.

MARGOT ADLER: And if the ruling is upheld, what are the implications for the FDA?

SCOTT BALLENGER: Well, it's hard to say exactly. In a very real sense, all that this case has been about thus far has been standard of review, what level of justification the FDA has to provide to defend its policies. If we win in the D.C. Circuit, then the case will go back to the district court under the narrowly tailored or compelling state interests standard, and the FDA will be forced to provide truly compelling justifications for interfering with patient freedom in this area. It is possible that the FDA could articulate truly compelling justifications for interfering with patient rights and if so then they would prevail. All that will happen as the result of a victory by Abigail Alliance in this case is a return to the district court and an opportunity for the FDA to explain why what it's doing is genuinely justified by compelling state interest.

MARGOT ADLER: And I would imagine that they will argue that scientific testing would be imperiled and so forth?

SCOTT BALLENGER: They will. Absolutely. And to some extent those arguments will be persuasive. But the Abigail Alliance's fundamental point in this lawsuit is that there may be circumstances in which it is necessary to restrict access to experimental drugs in order to protect the progress of science, but it is not necessary to restrict access to experimental drugs for everyone in order to protect the progress of science. For instance, if your concern is about incentives to participate in clinical trials, it makes no sense to deny the drugs to patients who are ineligible for the trial.

MARGOT ADLER: Do you see this as a case that could easily wend its way up to the Supreme Court?

SCOTT BALLENGER: I do. I believe it is the next great civil liberties case and that the court should take it.

MARGOT ADLER: I've heard that in arguing your case that you've compared it to some degree to the Cruzan case, which talked about being able to refuse treatment at the end of life. Tell me a little bit about this argument.

SCOTT BALLENGER: In the Cruzan case the Supreme Court recognized that any patient, even an actually relatively healthy patient, has a fundamental constitutional right to refuse all medical treatment--including proven medical treatment that could save their lives--and die. Well, if a person has a fundamental right to refuse all medical treatment and die, then why in the world don't they have a fundamental right to take a course of medical treatment that the FDA thinks is simply unproven and that might kill them? It doesn't make any sense to say that the federal Constitution protects a right to choose to die but not a right to choose to fight for your life.

MARGOT ADLER: Scott Ballenger is a lawyer who represents the Abigail Alliance in its lawsuit against the FDA. He's with the firm of Latham & Watkins in Washington, D.C. Thank you so much.

SCOTT BALLENGER: Thank you.

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MARGOT ADLER: Often the legal battle over whether patients should have access to untested drugs is framed in terms of what's best for patients and whether they have a right to make their own decisions about the course of treatment. But some doctors say that the risks of prescribing experimental drugs could do more harm than good. As an oncologist and chair of the Department of Clinical Bioethics at the National Institutes of Health, Dr. Ezekiel Emanuel has often found himself facing the delicate balance between doing everything he can to save a patient's life and knowing when all treatment options for that patient have been exhausted.

EZEKIEL EMANUEL: A patient of mine named Virginia came into my office. Her ankles were terribly swollen and her eyes were tinged with yellow. Five years earlier she had been treated for early-stage breast cancer. For a while she was fine, teaching third graders, living with her husband and four children. Then at age 56 her cancer came back and now it had spread to her lungs and liver. After a year and a half the conventional drugs used to fight breast cancer stopped working. Virginia still wanted to fight and she opted to try experimental drugs as part of a research trial. The day she came to my office Virginia had just completed a trial of a second experimental drug but it too had failed to stop the growth of the tumor in her liver.

One of the hardest parts of being an oncologist is explaining to a patient that her battle has come to an end. While I began talking to Virginia about palliative care and hospice, all she wanted to know was if there was another research trial she could enroll in, another experimental drug that she could take. I told her that her liver wasn't functioning adequately and she wasn't a good candidate for drug trials. Like many young, desperate patients, Virginia was willing to take almost anything: hair loss, infections, even a high chance of death on the unlikely prospect that an unproven drug could extend her life.

Recently the courts decided that such a gamble is the prerogative of terminally ill patients like Virginia. A D.C. Circuit court ruled 2-1 that dying patients have a constitutional right to any experimental drug that has passed the safety phase of human testing, Phase One, even while the drug's effectiveness is still untested and unproven. The court's ruling might seem like a victory for patients like Virginia, but it's not. What cancer patients really need are new drugs that are proven to fight cancer and cure cancer, not access to an array of unproven chemicals that provide false hope. Basically this court ruling is a throwback to a time a hundred years ago when unproven chemicals could be sold to unsuspecting patients. The vast majority of drugs that pass Phase One safety testing will fail in subsequent research and never make it to the market, proving not to be effective in the fight against cancer. Furthermore, drugs with minimal safety testing could actually increase the suffering of patients dying from cancer.

I gently explain to Virginia that investing all her energy chasing after another unproven drug is not going to help her or her family. Holding her hand I talk to her about spending time with her husband and daughters and making a videotape for her future grandchildren. We also discuss getting visiting nurses to come to her house. I saw her once more in my office. She was more accepting and found at least some of the activities meaningful. Because of her failing liver, less than three months later she lapsed into a coma and died with her family present.

As a doctor I know that the best way to care for my patients is to have many treatments that are proven to work. We can learn what works and what doesn't only by research trials. Giving patients access to drugs that have been shown to be safe on 30 or 50 patients but have not been shown effective in cancer trials betrays their trust to do what is best for them. It also prevents all of us from developing more proven drugs for the next Virginia whose cancer has come back.

MARGOT ADLER: Dr. Ezekiel Emanuel is an oncologist and chair of the Department of Clinical Bioethics at the National Institutes of Health.

MARGOT ADLER: That brings us to the end of our show today. You can go to our website, justicetalking.org, to find out more about experimental drugs for the seriously ill. While you're there, let us know what you think. You can also check out our blog, where many of the nation's leading commentators give you their views. And you can also podcast the show. Thanks for joining me. I hope you'll tune in next week. I'm Margot Adler.

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