Strategy to better protect public health by strengthening and rationalising EU pharmacovigilance (PV)
Public consultation on legislative proposals

As clinical pharmacologists involved in pharmacovigilance and directors of French regional pharmacovigilance centres, we take the opportunity to make some comments.

Section 3.2
3.2.1
The idea of a Pharmacovigilance Committee in place of the Pharmacovigilance Working Party is great. Ideally, this Committee should be independent of the Committee on Human Medicinal Products. Members of this Committee should also include the national pharmacovigilance committee chairpersons of each Member State, to have a better representativity of health professionals.

Proposals such as product withdrawal, restricted indications and new contraindications should be taken into account by National Pharmacovigilance Committees.

With regard to "products can be authorised earlier in their development and this is of crucial benefit to patient", we agree but suggest to change the sentence as follows: "products can be authorised earlier in their development **if** this is of crucial benefit to patient".

3.2.2 We agree with the concept of European Good Vigilance Practices, a useful tool for transparency, communication and harmonization within the Community.

3.2.3 This proposition seems to be only an economic measure.

3.2.4 With regard to the requirement of marketing authorisation holders to conduct risk management plans (RMPs) with EMEA and each competent authority; we can try to promote harmonization between countries and it is a nice idea to have a minimal common statement, but European RMP must sometimes be completed by specific studies, in accordance with local medical practices. Medicinal product safety and patient safety are not two separate entities, as national medical practices can vary greatly through the EU and this must be taken into account to assess patient safety.

3.2.5 If non-interventional safety studies are well designed, they could be of benefit for public health. However, when appropriate, public funding is necessary to assess risk.

3.2.6
It should be mandatory for health professionals to report all serious or new adverse effects to public pharmacovigilance systems, and possible to report to the industry (and not the opposite). It's impossible to be both judge and be judged.

Patients could report directly to the marketing authorisation holder or to the public pharmacovigilance system for all medicines.

Health professionals, must report first to the national pharmacovigilance system or to the regional pharmacovigilance centres where they exist. Validation and completeness of medical data are crucial for identifying pertinent signals and the national level is important to do this (language obstacles would appear to complete case reports from the EMEA). Accumulation of

a huge number of cases without quality control will not allow the right decision to be made at the right time.

3.2.7 We need Periodic Safety Update Reports with medical sense. Coding syndromes and not only lists of symptoms is necessary for appropriate decision making (line listing reports are not adequate for a safety assessment).

3.2.8 We agree on strengthening medicines safety transparency and communications

3.2.9 To improve safety warnings, short and strong messages in terms comprehensible by all concerned (patients and health professionals).

Regarding the text as a whole we would like to note that reducing the cost for industry is not the aim of an operational pharmacovigilance system to better protect public health (found 9 times in the text). To cure is costly but if we want to reduce adverse effects of medicines, public health should not be the target of cost cutting. National Pharmacovigilance systems must have public grants.

Annex I
Definitions We agree that the field of pharmacovigilance must be larger than the current definition of adverse reaction, which will be useful for a better assessment of risk. But definitions in medicine must be precise. Definitions such as unexpected adverse reaction, abuse, medical errors, etc. are useful to identify particular risks of medicines or risk in subgroups of patients (we do note that no definition for unexpected reaction is given, yet present on page 20).

The European qualified person is very important, but does this suggest that pharmacovigilance units of firms in each member state will disappear?

Directive 2001/83/EC article 22 (page 15)
Suppression of “exceptional circumstances” is dangerous; we understand (maybe we are wrong) that a marketing authorisation will be granted if there is a RMP included. This indeed reduces development time but a RMP does not ensure efficacy and safety.

Having a list of medicinal products to monitor will be useful for safety but national authorities must be allowed to complete this list, if necessary, *i.e.* in case of national public health problems. This list must be regularly updated.

Directive 2001/83/EC article 26 (page 17)
The suppression of “its therapeutic efficacy is insufficiently substantiated by the applicant; or”, is not justified.

Directive 2001/83/EC Title IX (articles 101-108)

Article 101a
Regarding "reporting suspected adverse reactions to the marketing authorisation holder or the competent authorities". Healthcare professionals must report to the competent authorities and, if they have time, to the marketing authorisation holder.
Pharmacovigilance is public health, and thus competent authorities must be informed first.

Data management and reporting

Section 1, articles 101d to 101f
101 e: how are patients able to make a statement of causal relationship between the event and the medicinal product?
If all adverse reactions that occur in the Community must be reported, this will generate more and more electronic transmissions, most of them being of little interest for risk assessment. To accumulate such a huge number of reports will not strengthen the current system.
We wonder if all patients, particularly the elderly, can report adverse reactions via websites. Certainly, many of them are able to do so, but electronic reporting can today only complete other means of reporting. We propose instead of "to facilitate the reporting of suspected adverse reactions…referred to in article 101i" (page 23), the following sentence: "Each member state could propose reporting of adverse reactions via their websites which shall be linked to the European medicines safety web-portal."

In conclusion, these proposals have some positive aspects, mainly the implementation of a Committee, of Good Pharmacovigilance Practices, a better communication on medicines safety, a list of medicines with reinforced surveillance, but also major drawbacks to better protect public health. Therapeutic benefit will no longer be necessary to obtain marketing authorization, inducing unacceptable exposure to risk for European citizens. By centralising and pooling non-validated or poorly documented data, signal detection will become more difficult. This will inturn make it more difficult for each member state to assess the real situation.
It's essential that national systems of Pharmacovigilance stays independent. Proper use of medicines, reducing preventable drug adverse reactions are national responsibilities: this can be reached only with independent teaching, continuing medical education, research, evaluation of medical practices, medical and scientific (not only administrative) assessment of risk. Quality of data (and not only quantity of data) collected through spontaneous reporting, must be one of the objective of pharmacovigilance for patient safety. We firmly believe that patient safety cannot be separated from medicines safety and is a national responsibility: the European level must coordinate the actions of national agencies but not replace them.

L'**A**ssociation française des **C**entres **R**égionaux de **P**harmaco**V**igilance