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CORPORATE ACCOUNTABILITY FOR SCIENTIFIC FRAUD: KETEK AND THE PERILS OF AGGRESSIVE AGENCY PREEMPTION

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* Joe R. and Teresa Lozano Long Endowed Chair in Administrative Law, University of Texas School of Law. This Article lies at the intersection of three major projects on which the author has labored for the past several years and will continue to pursue during the next two years. The first, an inquiry with my colleague Professor Wendy Wagner into the strategies that advocates in the private sector employ to “bend science” to support predetermined policy agendas, resulted in a recently published book. See THOMAS O. MCGARITY & WENDY A. WAGNER, *BENDING SCIENCE: HOW SPECIAL INTERESTS CORRUPT PUBLIC HEALTH RESEARCH* (2008). The second project describes and analyzes the efforts of common law defendants, joined more recently by some regulatory agencies, to persuade courts to find that state common law claims against the manufacturers of federally licensed products and activities are preempted by federal regulatory action. See THOMAS O. MCGARITY, *THE PREEMPTION WAR: WHEN FEDERAL BUREAUCRACIES TRUMP LOCAL JURIES* (2008). The final project, a forthcoming book, *Freedom to Harm*, examines the thirty-year project of free market advocates in corporate America, conservative think tanks, and academia to free companies of “unnecessary and burdensome” regulatory responsibilities and common law obligations.

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INTRODUCTION

The constant flow of news reports telling stories of corporate malfeasance has seriously undermined consumer confidence in the integrity of the marketplace. Consumers can no longer safely assume that their food is free of deadly microorganisms; that the tires on their SUVs will not fly apart while they are traveling down the highway; and that the toys they purchase for their children will not be contaminated with toxic chemicals. The reasons for this unfortunate turn of events are less obvious to the casual observer, but easily identified by careful students of the American legal system. Over the past thirty years, the companies that manufacture these products, and their allies in academia and business-oriented think tanks, have engaged in a sustained campaign to free themselves from “burdensome and unnecessary” regulatory responsibilities and “vexatious” common law liability stemming from “frivolous lawsuits” filed in state courts dominated by “greedy trial lawyers” and based on “junk science.”

To a surprising degree, these coordinated efforts to achieve “regulatory reform” and “tort reform” have been successful, and American companies are much freer to market potentially dangerous products than they were in the 1970s. Faced with intense competition from both foreign and domestic rivals, and freed from many previously applicable regulatory and common law responsibilities, some companies, and the consultants they employ, have apparently begun to reduce costs by cutting corners in many aspects of what they do, including their responsibility to manufacture products that meet consumer expectations for safety. In particular, some companies are less committed to the integrity of the scientific studies upon which they determine the safety and efficacy of their products, and with which they secure the requisite regulatory agency approval. Indeed, some companies are more inclined than ever to tolerate, or even encourage, affirmative deception and outright fraud in the conduct and presentation of those studies.

Unfortunately, the greatly debilitated, and sometimes politically dominated, federal enforcement regime has proven incapable of detecting and preventing much of this malfeasance and reducing its incidence to tolerable levels. Worse, the equally powerful incentive provided by the threat of state common law liability has, to a large extent, been neutered by the aggressive (and largely successful) efforts, of both the regulatory agencies and their regulated “clienteles,” to preempt state common law claims grounded in fraud perpetrated

on those agencies. Consequently, public confidence in the government's ability to ensure that the products we purchase are safe and effective is rapidly diminishing.

This Article examines this development at one critically important intersection of federal regulation and common law litigation—the evolving law of federal preemption of state common law litigation over damage caused by defective and mislabeled prescription drugs. Part I briefly describes the new drug approval process through which a manufacturer of a prescription drug must obtain approval from the Food and Drug Administration (FDA) for new products and for new uses of existing products. This Part highlights the interactions between the government relations departments of the pharmaceutical companies that produce much of the scientific information used in this process, the lower-level FDA officials who initially evaluate the studies and make recommendations to their politically appointed superiors, and the scientific advisory committees that typically assist the agency in this undertaking. Part II provides a case study of the dramatic failure of this process to protect consumers by using recently uncovered information concerning the antibiotic Ketek. Part III briefly describes the role that state common law can play in providing a backup for ensuring that manufacturers behave responsibly during the drug approval process and are held accountable when they do not.

Part IV describes the Supreme Court's decision in *Buckman Co. v. Plaintiffs' Legal Committee*,¹ in which the Court held, in a fairly unique factual setting, that the plaintiffs' common law claims based upon the fraud allegedly perpetrated by a consultant for a medical device manufacturer was preempted by federal law. Some lower courts have expanded the *Buckman* holding to preclude most, if not all, claims against drug and device manufacturers based on allegations of fraud on the agency. And, a deadlocked Supreme Court recently failed to resolve a conflict in the circuits in a case involving a fraud exception to a Michigan tort reform statute that would have offered some guidance on the extent to which federal law preempts common law claims based upon fraud on the agency, doctors, and patients.

Part V analyzes the arguments for and against preemption of fraud-on-the-agency claims in light of the Ketek experience and concludes that, on balance, preemption is a bad idea because federal enforcement alone provides

¹ 531 U.S. 341, 351 (2001).

inadequate incentives to companies that, because they face powerful economic pressures to show large profits to their shareholders, are inclined to cut corners. Although recent amendments to the agency's governing statute may alleviate the problem to some extent, they will not ensure that the FDA will detect and prosecute fraud, and they do not explicitly address the critical preemption problem. Part VI offers suggestions on how the lower courts should react to *Buckman*, how the Supreme Court can avoid extending *Buckman* when it next takes up the issue, and how Congress might go about reversing or limiting *Buckman* and empowering common law courts to reassume the vital backstop role that they have played in the past.

I. FDA APPROVAL OF NEW DRUGS

A. *The New Drug Application Process*

Under the Food, Drug, and Cosmetic Act (FDCA), the manufacturer of a prescription drug must obtain premarket approval from the FDA by demonstrating to the agency that the drug will be “safe and effective” for the approved uses and that its labeling will not be “false or misleading.”² The procedural vehicle for this showing is the new drug approval process, through which the manufacturer submits, and then FDA staff evaluates, a bulky New Drug Application (NDA). The NDA typically includes the results of chemical analyses, animal testing, pharmacological studies, and “clinical” trials in which doctors administer the new drug and either an existing drug or a placebo to human volunteers under controlled conditions and record information relevant to the safety and efficacy of the new drug.³ All of these studies, at least one of which must be an “adequate and well-controlled clinical investigation” in human beings, are done under the supervision and control of the drug companies or their contractors.⁴

The FDA staff responsible for evaluating new drug applications is located in the agency's Center for Drug Evaluation and Research (CDER).⁵ The

² Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 355(d), 393(b)(2)(B) (2006).

³ See generally PETER BARTON HUTT ET AL., *FOOD AND DRUG LAW* 576–734 (3d ed. 2007).

⁴ *Id.* at 677 (citing Peter Barton Hutt, *The Regulation of Drug Products by the United States Food and Drug Administration*, in *THE TEXTBOOK OF PHARMACEUTICAL MEDICINE* (John P. Griffin & John O'Grady eds., 5th ed. 2006)); see INST. OF MED. OF THE NAT'L ACADS., *THE FUTURE OF DRUG SAFETY: PROMOTING AND PROTECTING THE HEALTH OF THE PUBLIC* 33–39 (Alina Baciu et al. eds., 2007) [hereinafter *FUTURE OF DRUG SAFETY*].

⁵ HUTT ET AL., *supra* note 3, at 623.

CDER is divided into several divisions, each containing doctors and scientists with expertise in the groups of diseases that the division oversees.⁶ The project managers responsible for shepherding the application through the approval process carefully analyze the company's submissions and any other relevant information in the scientific literature or that otherwise comes to their attention.⁷ This process typically involves a number of meetings between the applicant and the staff to discuss such matters as the design of clinical trials, the ongoing conduct of those trials, and the proper interpretations of the study's results.⁸ It may also entail the issuance of one or more "nonapproval letters" demanding more scientific information before the staff is willing to issue an "approval letter" allowing the drug to be marketed for the approved uses.⁹

After the staff has prepared a written analysis of the scientific information in the new drug application, the agency usually refers the evaluation to one of several dozen standing advisory committees composed of doctors and scientists from academia and the private sector with expertise in the relevant diseases and existing treatments for those diseases. The advisory committees, in turn, make recommendations to the agency concerning the uses for which the drug should be approved and those for which sufficient scientific information does not exist to warrant approval. The FDA follows the recommendations of the advisory committees "[i]n the vast majority of cases."¹⁰ Once the FDA has issued an "approval letter" to the manufacturer, it is free to market the drug and promote it for the approved uses. The FDA has never had authority to regulate the practice of medicine, however, and thus lacks authority to limit the traditional practice of doctors to prescribe approved drugs and devices for unapproved uses.¹¹ About 21% of the 725 million prescriptions that doctors wrote in 2001 were for such "off-label" uses.¹²

⁶ See Office of Management Programs, Dep't of Health & Human Servs., FDA, Ctr. for Drug Evaluation and Research (May 1, 2008), <http://www.fda.gov/oc/orgcharts/cder1.pdf> (showing the organization of the CDER).

⁷ HUTT ET AL., *supra* note 3, at 693–94.

⁸ *Id.* at 683, 693; FUTURE OF DRUG SAFETY, *supra* note 4, at 44.

⁹ HUTT ET AL., *supra* note 3, at 693–94.

¹⁰ See *id.* at 724.

¹¹ See *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341, 350–51 & 351 n.5 (2001) (stating that "the FDCA expressly disclaims any intent to directly regulate the practice of medicine"); MARCIA ANGELL, *THE TRUTH ABOUT THE DRUG COMPANIES* 32 (2004) (stating that once a drug is on the market, doctors may prescribe it for any use and at any dose they deem appropriate); Randall S. Stafford, *Regulating Off-Label Drug Use—Rethinking the Role of the FDA*, 358 NEW ENG. J. MED. 1427, 1427 (2008) (explaining that the FDA has a "limited role once a drug is on the market" due to off-label prescriptions).

¹² FUTURE OF DRUG SAFETY, *supra* note 4, at 39.

Reacting to continual criticism from the pharmaceutical industry and various advocacy groups about “drug lag” in the United States,¹³ Congress enacted the Prescription Drug and User Fee Act of 1992 (PDUFA) with the explicit goal of speeding up the new drug approval process.¹⁴ The statute required companies to pay substantial “user fees” to cover the cost of hiring additional medical reviewers at the FDA, but it initially required the agency to devote the user fees exclusively to new drug review.¹⁵ As a quid pro quo for the industry, the statute subjected the FDA to strict deadlines in implementing the new drug approval process.¹⁶ At the same time, Congress created an abbreviated “fast track” approval process for new drugs to “address unmet medical needs” for “serious or life-threatening condition[s]” that has greatly reduced the time that the FDA takes to approve those drugs.¹⁷ Armed with these additional resources and motivated by the deadlines, the pace of the drug approval process picked up dramatically, and the United States became “increasingly the country of first launch, the kind of testing ground for new drugs.”¹⁸

Because no set of testing protocols can anticipate every possible adverse side effect of a drug in a diverse human population, the FDA’s premarket approval process cannot address all of a drug’s potential risks.¹⁹ In particular, the testing protocols for clinical trials employing limited numbers of human volunteers, over a limited time horizon of one to two years, are statistically incapable of detecting side effects that occur relatively rarely, have long latency periods, or adversely affect subpopulations (e.g., children and the elderly) that were not represented in the tested group.²⁰ Consequently, FDA approval of a drug for a particular use by no means guarantees that no one

¹³ See *id.* at 68–70.

¹⁴ PHILIP J. HILTS, *PROTECTING AMERICA’S HEALTH: THE FDA, BUSINESS, AND ONE HUNDRED YEARS OF REGULATION* 279 (2003).

¹⁵ *Id.* at 278.

¹⁶ See *Id.*; HUTT ET AL., *supra* note 3, at 679.

¹⁷ Catherine T. Struve, *The FDA and the Tort System: Postmarketing Surveillance, Compensation, and the Role of Litigation*, 5 *YALE J. HEALTH POL’Y L. & ETHICS* 587, 595 (2005) (citing 21 C.F.R. § 314.92 (2004)); see also HUTT ET AL., *supra* note 3, at 712–13.

¹⁸ *The Adequacy of FDA to Assure the Safety of the Nation’s Drug Supply: Hearings Before the Subcomm. on Oversight and Investigations of the H. Comm. on Energy and Commerce*, 110th Cong. 247 (2007) [hereinafter *The Adequacy of FDA*] (statement of Bruce M. Psaty, M.D., Professor, Medicine & Epidemiology, University of Washington).

¹⁹ See *FUTURE OF DRUG SAFETY*, *supra* note 4, at 33–39; MELODY PETERSEN, *OUR DAILY MEDS* 162 (2008).

²⁰ See, e.g., PETERSEN, *supra* note 19, at 225 (stating that drug companies rarely perform the studies needed to get their drugs approved for children).

taking it for that use will suffer adverse side effects and it has even less to say about the safety of the drug when taken for unapproved uses.²¹ The agency, therefore, has created a post-marketing surveillance program in the Office of Surveillance and Epidemiology and assigned the medical officers in that program the responsibility of monitoring existing sources of information relevant to the safety and efficacy of the drugs as they are used in the real world.²² Unlike the new drug approval staff, however, the staff responsible for post-marketing surveillance has not, until very recently, been able to take advantage of the user fees.²³

In response to an embarrassing scandal, in which a few generic drug companies obtained unfair advantages over their rivals in the abbreviated generic drug approval process by bribing FDA officials, the agency established an antifraud policy in September 1991 called the Applications Integrity Policy.²⁴ Under this policy, when FDA staff suspects that a manufacturer has engaged in fraud on the agency during the new drug approval process, the FDA issues a formal letter to the manufacturer requiring it to cooperate in the FDA investigation.²⁵ The manufacturer must identify all individuals that, to its knowledge, were involved in any fraudulent activity and remove them from any activities involving the FDA.²⁶ If fraud is found, it must also hire an outside consultant to conduct an internal review of the company's past practices and come up with a corrective action plan.²⁷ This process has done little to reduce attempts by manufacturers and their consultants to manipulate the drug approval process to their advantage.

²¹ See *Risk and Responsibility: The Roles of FDA and Pharmaceutical Companies in Ensuring the Safety of Approved Drugs, Like Vioxx: Hearing Before the Comm. on Government Reform*, 109th Cong. 23 (2005) (statement of Steven Galson, M.D., M.P.H., Acting Director, Ctr. for Drug Evaluation & Research, FDA) (recognizing "that there is no way [the FDA] can anticipate all possible effects of a drug from the clinical trials that precede approval"); FUTURE OF DRUG SAFETY, *supra* note 4, at 18 ("Of particular concern are the common but inaccurate perceptions that FDA approval represents a guarantee of safety"); DAVID MICHAELS, DOUBT IS THEIR PRODUCT: HOW INDUSTRY'S ASSAULT ON SCIENCE THREATENS YOUR HEALTH 153 (2008) (detailing minimal resources used for FDA post-marketing studies and failure to act on early indications of problems); Michael D. Green & William B. Schultz, *Tort Law Deference to FDA Regulation of Medical Devices*, 88 GEO. L.J. 2119, 2132–33 (2000) (highlighting that premarket clinical tests do not reveal many risks of a drug); Struve, *supra* note 17, at 587, 598–606 (same).

²² FUTURE OF DRUG SAFETY, *supra* note 4, at 51–59.

²³ *Id.* at 74.

²⁴ HUTT ET AL., *supra* note 3, at 739–40 (citing Hutt, *supra* note 4).

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

B. *Ketek as a Case Study in Regulatory Failure*

Ketek is the first drug in a recently developed class of antibiotics called “ketolides.”²⁸ This new class of drugs is, however, closely related to the “macrolide” class of antibiotics, which includes the familiar drugs azithromycin and erythromycin.²⁹ The pharmaceutical companies that have invested large sums in developing this new class of drugs hope that the ketolides are sufficiently different from the macrolides so that they will be effective against the many strains of infective bacteria that have become resistant to the macrolides and other antibiotics.³⁰ Several clinical trials that Aventis (now Sanofi-Aventis), the manufacturer of Ketek, submitted to the FDA in connection with its NDA for Ketek demonstrated that Ketek is effective in treating upper- and lower-respiratory tract infections, including pneumonia.³¹ In particular, it was shown to be effective in killing a particularly virulent bug, called *Streptococcus pneumoniae*, which has developed resistance to many of the existing antibiotics.³²

1. *FDA Approves Ketek for a Limited Use*

Aventis submitted its original NDA on February 28, 2000, several years after the Prescription Drug and User Fee Act of 1992 subjected the agency to strict approval deadlines in return for allowing the agency to collect substantial user fees from applicants to support the new drug approval process.³³ The FDA approval process for Ketek went through three cycles, a more extensive review than typically is required for prescription drugs.³⁴ During the first cycle, Ketek was evaluated by the FDA’s Division of Anti-Infective and

²⁸ The description of Ketek is taken primarily from the congressional testimony of FDA Commissioner Andrew C. von Eschenbach, delivered on March 22, 2007. *The Adequacy of FDA*, *supra* note 18, at 261, 263–65 (statement of Andrew C. von Eschenbach, Comm’r, FDA). It also draws on a letter written by Senator Charles E. Grassley that summarized the conclusions of a comprehensive sixteen-month investigation of agency documents and interviews with twenty-six current and former agency staffers. The investigation was conducted by the staff of the Senate Committee on Finance, under the direction of Senator Grassley, the Republican chairman of the committee at the time, and it encountered stiff agency resistance. Letter from Charles E. Grassley, Senator, Iowa, to Andrew C. von Eschenbach, Comm’r, FDA (Dec. 19, 2007), <http://finance.senate.gov/press/Gpress/2007/prg122007a.pdf> [hereinafter Letter].

²⁹ *The Adequacy of FDA*, *supra* note 18, at 261, 263–65 (statement of von Eschenbach).

³⁰ *See id.* at 263.

³¹ *Id.*

³² *Id.*

³³ Letter, *supra* note 28, at 4.

³⁴ *See The Adequacy of FDA*, *supra* note 18, at 263 (statement of von Eschenbach).

Ophthalmology Products (DAOP) in the CDER and by the FDA's Anti-Infective Drugs Advisory Committee (the Advisory Committee).³⁵

After reviewing the relevant scientific studies and hearing oral presentations from drug company scientists and DAOP staff, the Advisory Committee, by a vote of 7–3, recommended that the FDA approve Ketek to treat community-acquired pneumonia (cases of pneumonia acquired outside of institutions like hospitals and long-term care facilities).³⁶ At the same time, it recommended that the agency not approve Ketek for the far less serious diseases of acute bacterial sinusitis (common sinus infections that afflict millions of adults and children every year) and acute bacterial exacerbation of chronic bronchitis until Aventis submitted additional safety studies.³⁷ The Advisory Committee feared that Ketek could cause liver, heart, and visual side effects that might lead the agency to conclude that its benefits did not outweigh its risks for those less important uses.³⁸ It recommended that the FDA require Aventis to obtain additional safety information from a larger sample of patients to gain a better sense of the magnitude of the risks that ordinary usage posed for these serious side effects.³⁹ Some of the committee members also noted that the availability of other treatment options for sinusitis and acute flareups of chronic bronchitis weighed against hasty approval of Ketek for those uses.⁴⁰

Adhering closely to the committee's recommendations, the FDA sent a letter to Aventis on June 1, 2001, stating that it had approved Ketek for the limited use of treating community-based pneumonia, but that it needed additional information before it was willing to approve the drug for the sinusitis and chronic bronchitis uses.⁴¹ Soon thereafter, Aventis undertook an aggressive marketing campaign aimed at persuading doctors to prescribe Ketek for pneumonia.⁴² It became quite popular for treating that disease because bacteria that caused pneumonia were not yet resistant to Ketek.⁴³ Although it was unlawful for Aventis to market Ketek for other uses, it was perfectly

³⁵ *Id.*

³⁶ Letter, *supra* note 28, at 4.

³⁷ *The Adequacy of FDA*, *supra* note 18, at 263 (statement of von Eschenbach).

³⁸ *Id.*

³⁹ *Id.* at 263–64.

⁴⁰ Meeting of the Anti-Infective Drugs Advisory Committee 288–89 (Apr. 26, 2001), <http://www.fda.gov/ohrms/dockets/AC/cder01.htm>.

⁴¹ Letter, *supra* note 28, at 4.

⁴² See David B. Ross, *The FDA and the Case of Ketek*, 356 *NEW ENG. J. MED.* 1601, 1601 (2007) (discussing Aventis's recruitment of more than 1,800 physicians).

⁴³ See *The Adequacy of FDA*, *supra* note 18, at 263 (statement of von Eschenbach).

lawful under federal law for doctors to prescribe Ketek for unapproved uses, and they did so with apparent gusto.⁴⁴ By 2006, doctors were prescribing Ketek nationwide at a rate of about one prescription every four or five seconds.⁴⁵ Aventis's advertisements claimed that Ketek had "the most successful launch of any antibiotic in history."⁴⁶

2. *The FDA Fails to Inform the Advisory Committee of Serious Data Integrity Issues*

Aventis initiated the second cycle of the Ketek approval process when it submitted additional toxicity information to the FDA in July 2002.⁴⁷ Among the new studies was a very large clinical trial of Ketek, called Study 3014, involving 24,000 patients with outpatient respiratory track infections at approximately 1,800 study locations (or sites) throughout the country.⁴⁸ The first large "real world" pre-approval study ever undertaken for an anti-infective drug, Study 3014 was specifically designed to investigate Ketek's potential to cause adverse liver, heart, and visual effects.⁴⁹ After DAOP staff had analyzed the information from the additional studies, the agency convened the Advisory Committee for a second time on January 8, 2003.⁵⁰ On the basis of the new studies and "limited international post-marketing data" from other countries where Ketek was already in use, the Advisory Committee concluded that the scientific data supported the safety and efficacy of Ketek for sinusitis and acute exacerbation of chronic bronchitis, and it recommended that the FDA approve the drug for those additional uses.⁵¹ At a subsequent meeting of the Advisory Committee, the Director of the DAOP reported that the committee had based its recommendations "in large measure, on the safety data in Study 3014."⁵² Three of the seven members of the committee later acknowledged, in response to a congressional inquiry, that they had relied heavily on Study 3014 in

⁴⁴ See *supra* note 12 and accompanying text.

⁴⁵ *The Adequacy of FDA*, *supra* note 18, at 37 (statement of John Powers, M.D., Scientific Applications International Corporation).

⁴⁶ Ross, *supra* note 42, at 1603.

⁴⁷ *The Adequacy of FDA*, *supra* note 18, at 264 (statement of von Eschenbach).

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Letter, *supra* note 28, at 5 (citing Meeting of the Anti-Infective Drugs Advisory Committee 122 (Dec. 14–15, 2006), <http://www.fda.gov/ohrms/dockets/AC/06/transcripts/2006-4266t1-part2.pdf>).

drawing their conclusions and that they gave less weight to the post-marketing surveillance data from the foreign countries.⁵³

The DAOP did not, however, follow the committee's recommendation immediately. Instead, the FDA wrote Aventis to request additional information on the integrity of the data underlying Study 3014 and on the "incomplete post-marketing safety data from other countries."⁵⁴ The agency had, in fact, received indications of serious irregularities in the conduct of Study 3014, and it wanted Aventis to provide assurance that the data that it had submitted in connection with the study were accurate and reliable.⁵⁵ Although agency investigators had been aware of the irregularities for some time and had referred the conduct at one study site to its Office of Criminal Investigations (OCI), the FDA went forward with the Advisory Committee meeting at the scheduled time, without informing its members of any of the alleged irregularities.⁵⁶ Moreover, although the Ketek project manager who presented the overall safety information on Ketek at the first Advisory Committee meeting was prepared to discuss what he regarded as serious data integrity issues with respect to Study 3014 at the second meeting, he was told by his supervisors that the committee would not be permitted "to hear about the fraud issues."⁵⁷ In an e-mail dated January 2, 2003, the office director told him that it "would not be 'productive' to present the data integrity concerns [with Study 3014] to the advisory committee" and instead suggested that "having the company make the best possible presentation of their [post-marketing] data, focusing on information from countries where we have confidence in the reporting would be useful."⁵⁸ The project manager was also instructed by his immediate superior to "soften" the conclusions of his "safety team leader memo" on Ketek to provide upper-level officials in the CDER "more wiggle room" if called upon to explain the agency's decision.⁵⁹

The FDA's Commissioner, Dr. Andrew C. von Eschenbach, later explained that at the time of the second Advisory Committee meeting, the findings "were quite preliminary," and the agency had a policy of not disclosing "even the

⁵³ *Id.*

⁵⁴ *The Adequacy of FDA*, *supra* note 18, at 264 (statement of von Eschenbach).

⁵⁵ *Id.*

⁵⁶ *Id.*; *see also id.* at 32 (statement of Dr. David B. Ross); Ross, *supra* note 42, at 1602.

⁵⁷ *The Adequacy of FDA*, *supra* note 18, at 32 (statement of Ross).

⁵⁸ *Id.* at 231 (statement of Rep. Bart Stupak). With some justification, he concluded that if he had raised those issues at the meeting he "would have been fired immediately." *Id.* at 32 (statement of Ross).

⁵⁹ *Id.* at 48. This incident was also documented in an e-mail that became public in congressional hearings conducted in 2007. *See id.*

existence of a pending investigation” to avoid compromising it.⁶⁰ For that reason, the agency decided not to discuss the “data integrity issues of Study 3014 at the public Advisory Committee meeting.”⁶¹ It was apparently “not unusual for data from some sites to be eliminated from a study but to accept data from the other sites,” and that certainly was a possible outcome of this unfortunate situation.⁶² The agency did not, however, eliminate any data from the results of Study 3014 that the Advisory Committee considered at its January 2003 meeting.⁶³ The Commissioner testified that the agency staff understood that “any advice from the Committee would have to be later taken into account in the context of additional information about the integrity of data from Study 3014.”⁶⁴ This rationale is undercut somewhat by contemporaneous internal agency e-mail transmissions, later uncovered by a congressional oversight committee. For example, in an e-mail on December 10, 2003, the lead investigator for Ketek expressed the opinion that in light of the results of the agency’s ongoing investigation, the new drug application for the sinusitis and chronic bronchitis uses of Ketek “will have to be put on hold.”⁶⁵

3. *Scientific Fraud in Conducting Study 3014*

Not long before the Advisory Committee met, the DAOP had begun to receive reports of serious irregularities in the conduct of Study 3014 at the site with the highest enrollment, and shortly thereafter it received reports of less serious deficiencies at other sites.⁶⁶ By the time of the second Advisory Committee meeting, the FDA’s Division of Scientific Investigation (DSI) had conducted inspections at three of the locations that were collecting data for Study 3014, including a site in Gadsden, Alabama, that had the highest enrollment by far of any of the 1,800 sites employed in the study.⁶⁷ DSI

⁶⁰ *Id.* at 264 (statement of von Eschenbach).

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.* Commissioner von Eschenbach further testified that, in retrospect, “not bringing that advisory committee together until the issue of the data had been resolved would have been a more preferable and ideal way to approach it, and the way we should approach it in the future.” *Id.* at 225–26.

⁶⁵ *Id.* at 231.

⁶⁶ *Id.* at 264.

⁶⁷ See *The Adequacy of the FDA*, *supra* note at 27 (statement of Ann Marie Cisneros, Independent Clinical Research Associate) (stating that Dr. Kirkman-Campbell was the investigator at a site in Gadsden, Alabama); *id.* 264 (statement of von Eschenbach) (stating that there were more than 1,800 sites in the study); Letter, *supra* note 28, at 5 (stating that Dr. Kirkman-Campbell was the principal clinical investigator at the highest enrolling site). The DSI is the office within FDA’s Center for Drug Evaluation and Research that has the responsibility to “verify the integrity of efficacy and safety data submitted to the FDA in support of new

inspectors had visited the Gadsden site in mid-October 2002.⁶⁸ Having detected clear evidence that the principal investigator's enrollment and data management practices violated the FDA's regulations governing "Good Clinical Practices," the inspectors referred the matter to the agency's OCI.⁶⁹

When officials from the DAOP raised concerns over the conduct of Study 3014 with Aventis, the company told them that it was aware of "some data irregularities" and process concerns at the Gadsden site, but the company "assured FDA that there were no similar problems at any other sites."⁷⁰ A company representative later explained that good laboratory practice "deviations occur in virtually every large clinical study," and they "are typically successfully addressed through corrective actions."⁷¹ He maintained that both the company and the Contract Research Organization (CRO) it had hired to supervise the overall conduct of the study, "sought to correct or address [these] deviations, consistent with FDA regulations."⁷²

Contrary to Aventis's assurances, the two other sites that the DSI visited in December 2002 in connection with Study 3014 also revealed serious irregularities, and the inspectors recommended that the FDA undertake additional inspections of more sites.⁷³ This resulted in five more inspections in which DSI investigators identified many additional irregularities, some of which were of more concern than others.⁷⁴ An internal DSI memorandum summarizing its inspections of eight study locations concluded:

[Aventis and CRO] failed to detect the significant problems found during the FDA inspections, calling into question the utility of the sponsor monitoring to detect data integrity problems. If the on-site monitoring of these eight sites did not detect the significant

drug applications and to assure that the rights and welfare of human research subjects are protected." Division of Scientific Investigations, FDA, About DSI, <http://www.fda.gov/cder/Offices/DSI/aboutUS.htm> (last visited Oct. 11, 2008).

⁶⁸ Letter, *supra* note 28, at 5.

⁶⁹ *Id.* at 14.

⁷⁰ *The Adequacy of FDA*, *supra* note 18, at 264 (statement of von Eschenbach).

⁷¹ *Ketek Clinical Study Fraud: What Did Aventis Know? Hearing Before the Subcomm. on Oversight and Investigations, H. Comm. Energy and Commerce*, 110th Cong. (Feb. 12, 2008) (full transcript not yet available; for witness list and prepared testimony, visit http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Ketek.shtml) [hereinafter *Ketek Clinical Study Fraud*] (statement of Paul Herbert Chew, M.D., President, Research and Development, Sanofi-Aventis U.S. Inc., at 7, http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Chew-Testimony.pdf [hereinafter Chew]).

⁷² Chew, *supra* note 71, at 7.

⁷³ Letter, *supra* note 28, at 14.

⁷⁴ *Id.* at 6.

problems, there is no reason to expect that the on- or off-site monitoring of all sites would have fared better at detecting significant problems. For these reasons, the integrity of data from all sites involved in study 3014 cannot be assured with any degree of confidence.⁷⁵

The DAOP staff ultimately concluded that it could not rely upon data from Study 3014 for the purpose of approving Ketek for sinusitis and chronic bronchitis uses, but it nevertheless decided to issue approval letters based on foreign post-marketing data.⁷⁶

The OCI's findings were even more disturbing. After conducting a thorough investigation of the conduct of the principle investigator at the Gadsden site, Dr. Anne Kirkman-Campbell, the OCI "Special Agent in Charge" wrote a report in November 2002 concluding, among other things, that Dr. Kirkman-Campbell had engaged in several fraudulent activities and that there was "good reason to believe" that "Aventis may have had some knowledge of [her] activities."⁷⁷ He also told upper-level CDER personnel that it was his opinion that "Aventis knew sites were suspect but did nothing to prove or refute their suspicions."⁷⁸ The Special Agent recommended to his superiors that FDA create a small task force to investigate carefully all of the study sites that had enrolled one hundred or more patients for evidence of fraud and other misconduct.⁷⁹ Neither the Special Agent's supervisors in OCI nor upper-level officials in the agency, however, followed up on that recommendation.⁸⁰

The agency did follow up on the Special Agent's recommendation that Dr. Kirkman-Campbell be prosecuted for criminal violations of FDA regulations, and the matter was referred to the Department of Justice for prosecution.⁸¹ The full-scale investigation disclosed that only around fifty of the four hundred patients that she had reported as "enrolled" in the study actually received the

⁷⁵ *Id.* at 6–7.

⁷⁶ *Id.* at 8.

⁷⁷ *Id.* at 14 (quoting internal agency e-mail).

⁷⁸ *Id.* at 16; *see also Ketek Clinical Study Fraud*, *supra* note 71 (statement of Sen. Charles Grassley, Chairman, S. Finance Comm., at 2, http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Grassley-testimony.pdf [hereinafter Grassley] (testifying that the FDA did not want him to speak to the agent because it would reveal that the FDA did not investigate into the site more fully)).

⁷⁹ Letter, *supra* note 28, at 14.

⁸⁰ *Id.*

⁸¹ *Id.*

drug and that she had fabricated the rest.⁸² Dr. Kirkman-Campbell pleaded guilty to fraud in October 2003, and she was sentenced to a fifty-seven-month prison term in March 2004.⁸³ Additional investigations of the second and third highest enrolling sites by the DSI detected “significant violations of procedure that called into question the reliability of the data from those sites” as well.⁸⁴ The physician in charge of the third-highest enrolling site was later arrested on unrelated cocaine and weapons possession charges, indicating that he was definitely not the sort of physician that the “FDA likes to see in clinical trials.”⁸⁵

The critical remaining question for agency investigators was the extent to which Aventis was aware of the fraud and other serious misconduct in the conduct of Study 3014 at the time that it submitted the results of that study to the FDA for approval of Ketek for the sinusitis and chronic bronchitis uses. If it was aware of the fraud and misconduct, then both the company and the knowledgeable company officials responsible for submitting the defective data were potentially criminally liable.⁸⁶ Yet despite the OCI Special Agent’s conviction that Aventis was aware of at least some of the problems at the Gadsden site, and his recommendation that the agency appoint a small task force to investigate the extent of misconduct at other sites, both his superiors in the OCI and high level officials in the CDER were apparently very reluctant to open a full-scale investigation into the conduct of Aventis and its employees.⁸⁷

When the staff of the Senate Finance Committee subsequently investigated the FDA’s failure to prosecute Aventis, it encountered stiff resistance from upper-level agency officials.⁸⁸ The agency initially refused to allow the committee staff to interview the OCI Special Agent in Charge.⁸⁹ Committee Chairman Charles Grassley concluded that the agency “did not want anyone to know that it didn’t further investigate whether or not Aventis submitted fraudulent data knowingly to the FDA.”⁹⁰ Senator Grassley pointed out that “the FDA failed to act on the serious concerns raised by [the Special Agent in Charge] until almost two years after Ketek was approved [for the additional

⁸² *The Adequacy of FDA*, *supra* note 18, at 39 (statement of Cisneros).

⁸³ Ross, *supra* note 42, at 1602; Letter, *supra* note 28, at 5.

⁸⁴ *The Adequacy of FDA*, *supra* note 18, at 45 (statement of Ross).

⁸⁵ *Id.*

⁸⁶ See 18 U.S.C. § 1001 (2006); 21 U.S.C. § 333(a) (2006).

⁸⁷ Letter, *supra* note 28, at 14.

⁸⁸ Grassley, *supra* note 78, at 2.

⁸⁹ *Id.*

⁹⁰ *Id.*

uses] and almost three and a half years after Study 3014 was submitted to the FDA.”⁹¹

Had upper-level agency officials been at all curious about the extent to which Aventis employees knew of the fraud and other scientific misconduct that afflicted Study 3014, one obvious starting point would have been Dr. Kirkman-Campbell herself. In a prison interview conducted in May 2007, she told a reporter of her firm conviction that Aventis was equally at fault.⁹² There is no reason to believe that she would not have been willing to share with agency investigators any information she had to back up that conviction. She observed that Aventis “seemed to want to rush you through everything,” and it “didn’t care how you did it,” because it “wanted the trial over so they could get the data to the FDA.”⁹³ Dr. Kirkman-Campbell further related that after learning of the “deviations” in her research, the company nevertheless contracted with her to conduct a second study and flew her to a conference to educate her on how to market Ketek to other physicians.⁹⁴ Most damning of all, she reported that after the FDA called to schedule a routine audit of her site, Aventis “flew in two doctors to prep me and four to six girls to go through my files.”⁹⁵ The company ended its relationship with Dr. Kirkman-Campbell only after the FDA had initiated its criminal investigation.⁹⁶

Another obvious source of information on the extent of Aventis’s knowledge of the goings on at the Gadsden site would have been the employees of the CRO responsible under its contract with Aventis for ensuring the integrity of the data generated at all of the sites gathering data for Study 3014, including Gadsden, Alabama. Ann Marie Cisneros, one of the senior clinical research associates tasked with overseeing the progress of the study at the Gadsden location, later testified to a House of Representatives oversight committee that she had discovered that Dr. Kirkman-Campbell was engaged in fraud and that the fraud was well-known to both high-level officials in the CRO and to Aventis.⁹⁷ Even prior to the site visit that she conducted on

⁹¹ *Id.* at 6.

⁹² Kris Hundley, *Drug’s Chilling Path to Market*, ST. PETERSBURG TIMES, May 27, 2007, at A1, available at http://www.sptimes.com/2007/05/27/Worldandnation/Drug_s_chilling__path.shtml.

⁹³ *Id.*

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Ketek Clinical Study Fraud*, *supra* note 71 (statement of Ann Marie Cisneros, Independent Clinical Research Associate, at 4, http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Cisneros-Testimony.pdf [hereinafter Cisneros]).

February 27, 2002, “a number of ‘red flags’ were apparent.”⁹⁸ A Quality Assurance Audit conducted by Aventis personnel in early 2002 revealed the following: (1) the site had reported a suspiciously low number of adverse events and no “serious” adverse events at all; (2) no patients had withdrawn from the study and no patients were “lost to follow up, an unusual occurrence given the number of subjects”; and (3) patients were enrolled “within minutes of each other” at rates of nearly thirty per day, also highly unusual.⁹⁹ Another warning sign was the fact that the patients were reported to be one hundred percent compliant in taking their assigned medications.¹⁰⁰ Prior to conducting the visit, Cisneros reviewed the patient charts from the site and discovered that (1) every informed consent form bore some kind of discrepancy; (2) most of the forms looked like they had been signed by someone other than the subject; and (3) Dr. Kirkman-Campbell had enrolled her entire staff as patients for the study.¹⁰¹

The site visit, which occurred in 2002 before the FDA had approved any uses of Ketek, was even more revealing. Among other things, the site visit team determined that (1) the investigator had “failed to document critical source information”; (2) there were “many inconsistencies and modifications regarding patient signatures on Informed Consent forms”; and (3) “subjects appeared to have been randomized for the study in extremely high volumes during short time intervals.”¹⁰² Furthermore, an analysis of the blood samples taken during the study revealed that Dr. Kirkman-Campbell had assigned a single patient’s blood to multiple patients “in order to maximize enrollment totals.”¹⁰³ Cisneros told the oversight committee that she believed that “Aventis concretely knew of the fraud when their own [quality assurance] auditor . . . audited the site . . . a few weeks before my visit to the site in February 2002,” because “[t]he fraud was blatant [and] there was no attempt by the Investigator to cover it up.”¹⁰⁴

⁹⁸ *Id.* at 1.

⁹⁹ *Id.* at 2.

¹⁰⁰ *The Adequacy of FDA*, *supra* note 18, at 33 (statement of Cisneros).

¹⁰¹ Cisneros, *supra* note 97, at 2.

¹⁰² *Ketek Clinical Study Fraud*, *supra* note 71 (statement of Fred N. Eshelman, CEO, Pharmaceutical Product Development, Inc., at 4, http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Eshelman-Testimony.pdf [hereinafter Eshelman]); *see also The Adequacy of FDA*, *supra* note 18, at 85 (Ann Marie Cisneros’s answers to submitted questions) (detailing irregularities at the site).

¹⁰³ Eshelman, *supra* note 102, at 4.

¹⁰⁴ *The Adequacy of FDA*, *supra* note 18, at 84 (Cisneros’s answers to written questions).

Cisneros became so concerned for the welfare of Dr. Kirkman-Campbell's patients that she immediately called the Independent Review Board (IRB) that Aventis had hired to look out for the welfare of human subjects in Study 3014.¹⁰⁵ The President of the company managing the IRB shared her concerns, but "preferred to wait and see what actions Aventis took."¹⁰⁶ Cisneros never heard from the IRB after that, and she was unaware of any action taken by Aventis in light of their shared concerns.¹⁰⁷ Cisneros e-mailed her site visit findings to her superiors at the CRO and copied relevant Aventis personnel.¹⁰⁸ She also participated in a teleconference with officials from the CRO and Aventis during which she described her findings.¹⁰⁹ She later told a reporter that she "walked away from that meeting very frustrated" because she had "never seen a sponsor so lackadaisical about a site."¹¹⁰

Sometime after the conference call, Aventis informed the CRO that "it had analyzed the lab data and that the data was not indicative of scientific misconduct."¹¹¹ In addition, Aventis took site management responsibilities away from the CRO "because Dr. Kirkman-Campbell would not cooperate with anyone but the sponsor."¹¹² Aventis sent a follow-up letter to Dr. Kirkman-Campbell raising the issues that the CRO team had uncovered, but it did not ask the CRO to terminate Dr. Kirkman-Campbell's operations or to report her conduct to the FDA.¹¹³ After leaving the CRO, Cisneros received two calls from the CRO's lawyers reminding her "of the confidentiality agreement [she] signed" and advising her "not to speak with the FDA without Aventis approval" and only with an attorney from the CRO present at the conversation.¹¹⁴

¹⁰⁵ Cisneros, *supra* note 97, at 3. A representative for the company that managed the IRB testified to a House Committee in 2007 that the company had no recollection of the conversation Cisneros related and no documentation of any such conversation. However, it recanted that testimony in hearings conducted in February 2008 after finding documentation of the phone call. The company admitted that "[c]ontrary to both procedure and training, this memorandum was not forwarded to a supervisor or to the Institutional Review Board as it should have been at the time," and that it was not "placed in the investigator file as it should have been." *Ketek Clinical Study Fraud*, *supra* note 71 (statement of Sharon Hill Price, CEO and Chairperson of the Board of Directors, The Copernicus Group IRB, at 2, http://energycommerce.house.gov/cmte_mtgs/110-oi-hrg.021208.Price-Testimony.pdf).

¹⁰⁶ Cisneros, *supra* note 97, at 3.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*; Eshelman, *supra* note 102, at 4.

¹¹⁰ Hundley, *supra* note 92.

¹¹¹ Eshelman, *supra* note 102, at 5.

¹¹² Cisneros, *supra* note 97, at 3.

¹¹³ Eshelman, *supra* note 102, at 5.

¹¹⁴ Cisneros, *supra* note 97, at 4.

The agency did not open a full-scale criminal inquiry into Aventis's conduct as the study's sponsor until March 2006.¹¹⁵ An internal agency e-mail from another OCI agent dated April 17, 2007, related his conclusion that the company was aware of the fact that significant data quality issues existed at several of the sites of Study 3014, but nevertheless claimed that the study had been conducted in accordance with good laboratory practices when Aventis submitted it to the FDA.¹¹⁶ Despite these serious allegations from two members of the FDA staff assigned to conduct criminal investigations, the agency closed the case against Aventis in July 2007 with the issuance of a warning letter to the company.¹¹⁷

4. FDA Approves Ketek for Additional Uses

The third review cycle began when the FDA received the company's response in October 2003, almost a year after the DSI and the OCI had uncovered fraud at the Gadsden, Alabama, site and the DSI had uncovered serious irregularities at other study sites.¹¹⁸ By then, the company had discontinued Dr. Kirkman-Campbell's participation in the study, but it did not remove the data generated by her site from the results that it submitted to the FDA.¹¹⁹ The submission also included explanatory material on the growing number of reports on "spontaneous adverse events" in connection with the 4 million prescriptions for Ketek filled in other countries.¹²⁰ In addition to this information submitted by Aventis, the DAOP staff considered audits of the clinical trials conducted by the agency's DSI on Study 3014 and, presumably, the information that the OCI communicated to the Ketek Project Manager and the Deputy Director of the Office of New Drugs in the CDER.¹²¹ The DAOP ultimately concluded that it could not explicitly rely upon Study 3014 to justify its decision because of "the systematic failure of the sponsor's monitoring of the clinical trial to detect clearly existing data integrity problems."¹²² Commissioner von Eschenbach later testified to a congressional oversight committee that the agency did not consider Study 3014 in deciding whether to approve Ketek for the additional uses.

¹¹⁵ Grassley, *supra* note 78, at 3.

¹¹⁶ *Id.* at 4.

¹¹⁷ Letter, *supra* note 28, at 14.

¹¹⁸ *The Adequacy of FDA*, *supra* note 18, at 264 (statement of von Eschenbach).

¹¹⁹ Hundley, *supra* note 92; Letter, *supra* note 28, at 17 n.15.

¹²⁰ *The Adequacy of FDA*, *supra* note 18, at 264 (statement of von Eschenbach).

¹²¹ Letter, *supra* note 28, at 15.

¹²² *The Adequacy of FDA*, *supra* note 18, at 265 (statement of von Eschenbach).

According to contemporaneous internal agency correspondence and the FDA employee who was the primary Ketek reviewer for the agency at the time, however, agency officials did rely on Study 3014 “and repeatedly cited it as evidence of Ketek’s safety” during the internal agency review.¹²³ For example, the Deputy Director of the Office of New Drugs sent an e-mail on March 21, 2006, stating that the staff “did not completely ignore the data from the 3014 study, but assessed those [adverse events] . . . that were identified to qualitatively assess patterns of toxicity.”¹²⁴ Moreover, the FDA’s website cited Study 3014 in its public explanation for its approval of Ketek for treating sinusitis and chronic bronchitis.¹²⁵

The agency approved Ketek for sinusitis and exacerbation of chronic bronchitis on April 1, 2004, and decided to leave the approval for pneumonia in place.¹²⁶ The primary support that the agency cited for the decision (at least that it acknowledged publicly) came from the much smaller clinical trials that Aventis submitted earlier and the “international post-marketing experience.”¹²⁷ Based on “extensive interviews with other FDA representatives as well as a review of thousands of documents,” the staff of the Senate Finance Committee concluded that the agency had relied almost exclusively on the foreign post-marketing studies.¹²⁸ For example, the minutes of a teleconference between agency staff and Aventis scientists related that “Aventis may need to rely on the analyses of foreign post-marketing experience to support the safety of [Ketek] if the results of study #3014 are not acceptable.”¹²⁹ It noted that none of the studies that Aventis submitted in response to the Advisory Committee’s request for additional information, other than the foreign post-marketing data, directly related to the adverse health effects of Ketek.¹³⁰

This marked the first time that the agency had relied primarily on foreign post-marketing data to support the approval of a prescription drug.¹³¹ Analyses

¹²³ *Id.* at 26 (statement of Ross).

¹²⁴ *Id.* at 32 (quoting internal FDA e-mail).

¹²⁵ *Id.* at 232 (statement of von Eschenbach).

¹²⁶ *Id.* at 265.

¹²⁷ *Id.*

¹²⁸ Letter, *supra* note 28, at 8.

¹²⁹ *Id.* (quoting internal FDA memorandum).

¹³⁰ *Id.* at 8–9.

¹³¹ *Id.* Dr. David Graham, the Associate Director for Science and Medicine in the FDA’s Office of Surveillance and Epidemiology, could not “think of a single other example where FDA used such data as the primary basis for approval of a drug’s safety.” *The Adequacy of FDA*, *supra* note 18, at 59 (statement of David Graham, M.D., MPH, Associate Director, Science and Medicine, FDA Office of Surveillance and Epidemiology).

of large data sets of post-marketing reports can reveal adverse effects that clinical studies based on much smaller populations are incapable of detecting. The agency's regulations, therefore, require manufacturers to submit available foreign post-marketing data with their NDAs.¹³² In the case of Ketek, for example, the post-marketing data revealed a risk that Ketek exacerbated Myasthenia Gravis (literally "grave muscle weakness"), a chronic autoimmune neuromuscular disease that causes weakness in the body's skeletal muscles, and the agency consequently demanded that Aventis add a statement to the warning section of the Ketek product label to that effect.¹³³ At the same time, the quality of the data collected in uncontrolled post-marketing studies, in general, and foreign post-marketing studies, in particular, are generally not as reliable as the data generated by prospective clinical trials.¹³⁴

A subsequent investigation by the staff of the Senate Committee on Finance revealed that many reviewers in the DAOP were uncomfortable with relying heavily upon post-marketing data:

[T]hey noted the underreporting of adverse events, reporting or recall bias because physicians, patients, or both do not adequately recall or report details of the event, incomplete submissions, which make[] it difficult to assess causality, and the lack of an appropriate denominator, the total number of patients exposed to the risk, for calculating the rate of an adverse event.¹³⁵

Internal agency e-mails also revealed considerable concern for the greatly differing rates of adverse event reporting in the countries in which Ketek had been marketed.¹³⁶ Commissioner von Eschenbach explained that the foreign data on Ketek were extensive and that the DAOP staff was careful to take into account the very real possibility of "under-reporting" of adverse events in post-marketing data.¹³⁷ An agency spokesperson later offered another explanation

¹³² See *id.* at 265 (statement of von Eschenbach) (describing the agency's consideration of international post-marketing data).

¹³³ *Id.* The team leader in the Office of Antimicrobial Products with responsibility for Ketek, however, later testified that the warning had been "watered down" during negotiations with Aventis over its content. *Id.* at 53 (statement of Ross). In his view, the FDA should have the authority to mandate label changes. *Id.* (citing the example of Myasthenia Gravis).

¹³⁴ Ross, *supra* note 42, at 1602-03.

¹³⁵ Letter, *supra* note 28, at 9.

¹³⁶ *Id.* at 10.

¹³⁷ *The Adequacy of FDA*, *supra* note 18, at 265 (statement of von Eschenbach).

for the unprecedented action: “We don’t want to disincentivize companies interested in going after these bad bugs.”¹³⁸

5. FDA Withdraws Recently Added Uses

Seven months after Ketek became available in the United States in February 2002, the FDA received the first report of a death caused by Ketek-associated liver failure in a patient treated for a mild respiratory infection, an off-label use at that time.¹³⁹ The report was filed away, and the information was duly reported several months later in an internal FDA safety review.¹⁴⁰ In connection with the first anniversary of its approval, the agency undertook a “comprehensive safety review” of Ketek in March 2005.¹⁴¹ Although it discovered one case of liver failure associated with Ketek in the domestic post-marketing data, it “was not clear” to the agency whether this represented “a signal beyond what had been seen in the data available at the time of approval.”¹⁴² That conclusion offered small comfort to the family of a twenty-six-year-old construction worker from Mexico whose doctor had prescribed Ketek to fight a sinus infection resulting from a cold.¹⁴³ Three weeks later, he became the statistic that the agency subsequently ignored.¹⁴⁴

In January 2006, however, the FDA received word that a study concluding that Ketek had caused three cases of serious liver toxicity, one of which resulted in the patient’s death, was soon to be published in the *Annals of Internal Medicine*.¹⁴⁵ Commissioner von Eschenbach later admitted that all three cases had been reported to the FDA, “although in less detail, making conclusions about them difficult to reach until the published information was available.”¹⁴⁶ In fact, the fatality that the study reported was Ramino Obrajero Pulquero.¹⁴⁷ The publication study inspired the FDA to issue a Public Health Advisory informing doctors and the public of the new information and

¹³⁸ Marc Kaufman, *Senator’s HHS Trip for Antibiotic Data Yields Only Ire*, WASH. POST, June 15, 2006, at A10.

¹³⁹ Ross, *supra* note 42, at 1603.

¹⁴⁰ *Id.*

¹⁴¹ *The Adequacy of FDA*, *supra* note 18, at 265 (statement of von Eschenbach).

¹⁴² *Id.*

¹⁴³ Hundley, *supra* note 92.

¹⁴⁴ *Id.*

¹⁴⁵ Ross, *supra* note 42, at 1603 (citing Kimberly D. Clay et al., *Brief Communication: Severe Hepatotoxicity of Telithromycin: Three Case Reports and Literature Review*, 144 ANNALS INTERNAL MED. 415 (2006)).

¹⁴⁶ *The Adequacy of FDA*, *supra* note 18, at 265–66 (statement of von Eschenbach).

¹⁴⁷ Hundley, *supra* note 92.

announcing that the agency would be undertaking another “comprehensive review” of Ketek, focusing particularly on liver toxicity.¹⁴⁸ During February 2006, high-level agency officials also received written warnings from low-level FDA reviewers about the fraud and irregularities that they had detected in the conduct of the Ketek study at more than one location.¹⁴⁹ These overtures, however, did not inspire FDA management to take any further action. Instead, Commissioner von Eschenbach “summoned” FDA reviewers to a June 2006 meeting at which he admonished them that “if they told anyone outside the FDA about the problems with Ketek, they’d be ‘traded from the team,’” an expression that at least one reviewer took as a threat to his employment.¹⁵⁰ By this time, Ketek had already been linked to twenty-three cases of acute liver damage and twelve cases of acute liver failure, four of which were fatalities.¹⁵¹

After completing the promised “comprehensive review,” the agency on June 29, 2006, issued a press release informing the public that it would require Aventis to include a new warning about liver toxicity on Ketek’s label.¹⁵² At about the same time, Aventis voluntarily halted its ongoing pediatric trials of Ketek’s efficacy in treating sinusitis in children and modified the Ketek label to warn about the liver toxicity risks and strengthen the warning to patients with Myasthenia Gravis.¹⁵³ Because the agency did not, however, take any action to restrict any of the approved uses of the drug, pediatricians could still prescribe it for treating sinus infections in kids.¹⁵⁴ By this time, doctors had written over 5 million prescriptions for Ketek, and the company had grossed nearly \$400 million in U.S. sales.¹⁵⁵

¹⁴⁸ *The Adequacy of FDA*, *supra* note 18, at 266 (statement of von Eschenbach).

¹⁴⁹ *Id.* at 137 (statement of Ross).

¹⁵⁰ *Id.* at 137–38. Commissioner von Eschenbach later testified to a House oversight committee:

[I] wish to provide an environment, if you will, a locker room, an environment in which people with diverse points of view, completely different perspectives on an issue or problem that can come together with mutual respect and vigorously, even aggressively, debate and discuss those issues, and do that in the comfort of that being respected and supported and even encouraged—even, quite candidly, from my standpoint, expected.

Id. at 214 (statement of von Eschenbach). Those familiar with locker room etiquette in situations in which the coach is involved in the conversation will no doubt find this metaphor an odd way to capture the concept of aggressive debate over contentious issues.

¹⁵¹ Ross, *supra* note 42, at 1603.

¹⁵² *The Adequacy of FDA*, *supra* note 18, at 266 (statement of von Eschenbach).

¹⁵³ Letter, *supra* note 28, at 7.

¹⁵⁴ See Gardiner Harris, *Halt Is Urged for Trials of Antibiotic in Children*, N.Y. TIMES, June 8, 2006, at A16 (5 million prescriptions).

¹⁵⁵ *Yet More Suffer as FDA Betrays Trust*, ST. PETERSBURG TIMES, May 31, 2007, at A12, available at http://www.sptimes.com/2007/05/31/Opinion/Yet_more_suffer_as_FD.shtml.

On December 14 and 15, 2006, the agency convened the Advisory Committee for the third time to evaluate the new information on liver toxicity.¹⁵⁶ The agency was also concerned that the “noninferiority” clinical trials upon which the agency had based its previous approvals no longer met accepted standards of testing for drug efficacy.¹⁵⁷ This time, the committee concluded that the benefits of Ketek for treating acute bacterial sinusitis and acute bacterial exacerbation of chronic bronchitis did not outweigh the risks of liver toxicity, heart disease, and visual impairment, but the benefits continued to outweigh the risks for community-acquired pneumonia.¹⁵⁸ It further recommended that the FDA include a “black box” warning,¹⁵⁹ the most extreme of the warnings in the agency’s arsenal,¹⁶⁰ about liver toxicity on Ketek’s label.¹⁶¹ Finally, on February 12, 2007, the day before a scheduled congressional hearing on the agency’s actions related to Ketek, the agency announced that it had taken action along the lines of the Advisory Committee’s recommendations.¹⁶² Doctors were still free, however, to prescribe Ketek for any unapproved use, including treating sinus infections in kids.¹⁶³

II. THE COMMON LAW BACKSTOP

A. *The Common Law of Products Liability*

Nineteenth-century common law courts did not impose liability on sellers of products outside of express or implied warranties made to consumers of those products.¹⁶⁴ Ever adaptable, however, American courts in the 1960s and early 1970s invoked implied warranty concepts from the law of contracts to

¹⁵⁶ *The Adequacy of FDA*, *supra* note 18, at 266 (statement of von Eschenbach).

¹⁵⁷ Letter, *supra* note 28, at 7. In noninferiority trials, one group of patients that receives a medication of known efficacy against the relevant disease is compared to another group that receives the drug of interest. Effectiveness is established if the latter drug is equivalent, or at least not substantially worse, in treating the disease as the former. For diseases that the human body’s immune system will fight off over time in any event, it is also possible that neither drug was particularly effective in helping the body fight off the infection. In that case, a successful noninferiority clinical trial only demonstrates that the new drug is no more effective than the older drug in fighting the disease. *See id.* at 7 n.10 (addressing this in the case of Ketek).

¹⁵⁸ *See* Anna Wilde Mathews, *Sanofi Antibiotic Takes Hit from FDA Advisors*, WALL ST. J., Dec. 16–17, 2006, at A3; Stephanie Saul, *Antibiotic Receives Low Grade from Federal Panel, Which Urges Limits and Warnings*, N.Y. TIMES, Dec. 16, 2006, at A11.

¹⁵⁹ *See* Mathews, *supra* note 158.

¹⁶⁰ HUTT ET AL., *supra* note 3, at 727 n.3.

¹⁶¹ *The Adequacy of FDA*, *supra* note 18, at 266 (statement of von Eschenbach).

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ Douglas A. Kysar, *The Expectations of Consumers*, 103 COLUM. L. REV. 1700, 1709 (2003).

impose liability for negligently designed and manufactured products without regard to strict common law notions of privity of contract.¹⁶⁵ The seminal *Restatement (Second) of Torts* provided that a person who “sells any product in a defective condition unreasonably dangerous to the user or consumer or to his property is subject to liability for physical harm thereby caused to the ultimate user or consumer, or to his property,” even though the seller “has exercised all possible care in the preparation and sale of his product.”¹⁶⁶ The *Second Restatement* explained that a defective condition is “a condition not contemplated by the ultimate consumer.”¹⁶⁷ This “consumer expectation” test was “objective” in that it did not turn on what any particular plaintiff expected, but on what a reasonable consumer in the plaintiff’s position would have expected in the way of safety or warnings.¹⁶⁸ Nevertheless, it made manufacturers intensely uncomfortable to know that liability rested on what consumers expected, rather than on an assessment of the risks and benefits of the product based on information that was far more likely to be under their control.

In an explanatory comment, the *Second Restatement* created an important qualifier for “unavoidably unsafe” products.¹⁶⁹ The comment noted the existence of “some products which, in the present state of human knowledge, are quite incapable of being made safe for their intended and ordinary use” and cited drugs and vaccines as examples.¹⁷⁰ When “properly prepared, and accompanied by proper directions and warning,” these products are not defective and should not be regarded as unreasonably dangerous.¹⁷¹ The primary focus in products liability cases involving food, drugs, cosmetics, cigarettes, and the like has, therefore, been on the manufacturer’s duty to provide proper warnings and instructions. Consequently, a claim that a federal regulation governing the warnings that must accompany such products preempts state common law actions is effectively a claim that the entire field of products liability is preempted.¹⁷²

¹⁶⁵ E.g., MARK A. GEISTFELD, *PRINCIPLES OF PRODUCTS LIABILITY* 10–19 (2006); DAVID G. OWEN, *PRODUCTS LIABILITY LAW* 17–20 (2005); Kysar, *supra* note 164, at 1709–14.

¹⁶⁶ RESTATEMENT (SECOND) OF TORTS § 402A (1965); *see also* GEISTFELD, *supra* note 165, at 16–19.

¹⁶⁷ RESTATEMENT (SECOND) OF TORTS § 402A cmt. g.

¹⁶⁸ OWEN, *supra* note 165, at 293–96; *see also* GEISTFELD, *supra* note 165, at 26. *See generally* Jerry J. Phillips, *Consumer Expectations*, 53 S.C. L. REV. 1047 (2002).

¹⁶⁹ RESTATEMENT (SECOND) OF TORTS § 402A cmt. k.

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *See* OWEN, *supra* note 165, at 895–97; George W. Conk, *Is There a Design Defect in the Restatement (Third) of Torts: Products Liability?*, 109 YALE L.J. 1087, 1093 (2000); Margaret Gilhooly, *Innovative*

The *Restatement (Third) of Torts: Products Liability*, published on May 20, 1997, avoided any reference to “strict liability,” assigned the consumer expectation test to the minor status of a consideration in product design cases, and elevated the risk-utility test to prominence.¹⁷³ The *Third Restatement* articulation subjects to liability anyone “engaged in the business of selling or otherwise distributing products” for harm to persons or property damage caused by “a defective product.”¹⁷⁴ A “defect” must fall into one of three fairly restrictive categories: (1) a “manufacturing defect” that occurs when the product “departs from its intended design”; (2) a design defect that results “when the foreseeable risks of harm posed by the product could have been reduced or avoided by the adoption of a reasonable alternative design . . . and the omission of the alternative design renders the product not reasonably safe”; or (3) a warning defect that occurs “because of inadequate instructions or warnings when the foreseeable risks of harm posed by the product could have been reduced or avoided by the provision of reasonable instructions or warnings . . . and the omission of the instructions or warnings renders the product not reasonably safe.”¹⁷⁵

The *Restatement* for the first time specifically addressed prescription drugs and medical devices, providing that a drug or device is defectively designed only if “the foreseeable risks of harm” are sufficiently great in relation to the drug’s or device’s foreseeable therapeutic benefits “that *reasonable health-care providers*, knowing of such foreseeable risks and therapeutic benefits, would not prescribe the drug or medical device for *any* class of patients.”¹⁷⁶ Similarly, a prescription drug or medical device is unreasonably unsafe due to inadequate instructions or warnings only

if reasonable instructions or warnings regarding foreseeable risks of harm are not provided to: (1) prescribing and other health-care providers who are in a position to reduce the risks . . . ; or (2) the patient when the manufacturer knows or has reason to know that health-care providers will not be in a position to reduce the risks of harm in accordance with the instructions or warnings.¹⁷⁷

Drugs, Products Liability, Regulatory Compliance, and Patient Choice, 24 SETON HALL L. REV. 1481, 1489 n.29 (1994); Struve, *supra* note 17, at 10.

¹⁷³ See GEISTFELD, *supra* note 165, at 26–27; Kysar, *supra* note 164, at 1718–22; Phillips, *supra* note 168, at 1047–48.

¹⁷⁴ RESTATEMENT (THIRD) OF TORTS: PRODUCTS LIABILITY § 1 (1998).

¹⁷⁵ *Id.* §§ 1–2.

¹⁷⁶ *Id.* § 4 cmt. b (emphasis added).

¹⁷⁷ *Id.* §§ 6(c)–(d).

An explanatory comment noted that most courts had been reluctant to impose liability for inadequate design and warnings on manufacturers of prescription drugs and devices because prescribing physicians are “learned intermediar[ies]” who could ensure that “the right drugs and medical devices reach the right patients,” and because “government regulatory agencies adequately review new prescription drugs and devices, keeping unreasonably dangerous designs off the market.”¹⁷⁸ Another comment cautioned that manufacturers of drugs and devices “have the responsibility to perform reasonable testing prior to marketing a product and to discover risks and risk-avoidance measures that such testing would reveal,” thereby opening the door to liability for inadequate testing and surveillance on the part of drug manufacturers.¹⁷⁹

It is fair to say that, unlike the *Second Restatement* test for “strict products liability,” the *Third Restatement* formulation has not swept the country. Numerous courts have adopted the *Third Restatement*, but many remain deeply suspicious of what several scholars view as a thinly veiled attempt to enhance the role of experts and limit the role of juries.¹⁸⁰ Critics of the *Third Restatement* in academia maintain that the American Law Institute, “virtually without debate,” reversed “thirty-five years of safety-advancing products-liability law” when it prescribed a separate test for drugs and devices that depended upon whether a reasonable doctor would prescribe it for *any* use,¹⁸¹ thereby allowing drug manufacturers to escape liability even in cases in which they know full well that doctors will be prescribing the drug for unapproved uses.¹⁸² One of the *Third Restatement* reporters responded that the courts owed “substantial deference to a marketplace for prescription drugs that appears to function almost perfectly,”¹⁸³ a highly dubious proposition in light of the Ketek

¹⁷⁸ *Id.* § 6 cmt. b.

¹⁷⁹ *Id.* § 6 cmt. g.

¹⁸⁰ See GEISTFELD, *supra* note 165, at 26–29; OWEN, *supra* note 165, at 33; Kysar, *supra* note 164, at 1703, 1726–28; see also, e.g., Potter v. Chicago Pneumatic Tool Co., 694 A.2d 1319 (Conn. 1997) (holding that the issue of whether tools were defectively designed was for the jury to decide).

¹⁸¹ Conk, *supra* note 172, at 1088–89, 1094.

¹⁸² See Teresa M. Schwartz, *Regulatory Standards and Products Liability: Striking the Right Balance Between the Two*, 30 U. MICH. J.L. REFORM 431, 459 (1997); see also Teresa M. Schwartz, *Prescription Products and the Proposed Restatement (Third)*, 61 TENN. L. REV. 1357, 1380 (1994) [hereinafter Schwartz, *Prescription Products*] (“In sum, the plaintiff must prove that the drug or device should not have been on the market at all.”).

¹⁸³ James A. Henderson, Jr., *Prescription Drug Design Liability Under the Proposed Restatement (Third) of Torts: A Reporter’s Perspective*, 48 RUTGERS L. REV. 471, 481 (1996).

revelations and other clear evidence of regulatory failure in the context of several recently approved drugs.

B. The Corrective Justice and Protective Justice Functions of the Common Law of Torts

Prior to the 1970s, judges and legal scholars took it for granted that the primary function of state common law was to administer “corrective justice,” a concept with philosophical origins in the writings of Aristotle and a strong grounding in everyday common sense. Corrective justice requires the law to correct unjust changes in wealth that result from involuntary interactions among members of a relevant community through after-the-fact financial adjustments.¹⁸⁴ Thus, when a defendant behaves unreasonably or markets an unreasonably dangerous product, the law should require the defendant to compensate individuals who can demonstrate that the behavior or product proximately caused them legally recognizable harm.¹⁸⁵ Entities whose activities pose relatively high risks to others could purchase liability insurance and, thereby, ensure in advance that compensation would be paid, albeit often in a dilatory fashion, and the responsible actors, not the government, would bear their fair share of the ultimate responsibility for the welfare of the victims.

The “law and economics” movement, which became a powerful new force in legal scholarship in the 1970s, assigned a wholly different “protective justice” role to tort liability.¹⁸⁶ Focusing on the economic incentives tort liability provides to those producing risky products or engaging in potentially dangerous activities, legal scholars trained in law and economics suggested that the proper function of tort law was to achieve allocative efficiency by sending appropriate signals to companies to conduct their activities and design and manufacture their products in ways that maximize the net benefit to society.¹⁸⁷ The sole test for allocative efficiency (or societal wealth

¹⁸⁴ According to Professor Christopher Schroeder, common law liability achieves corrective justice when it meets the following three conditions: (1) individual liability must be assessed consistently with moral norms of responsibility for one’s actions; (2) victims must be made whole (compensated); and (3) the resources for satisfying (2) must come exclusively from the liability payments required by (1). Christopher H. Schroeder, *Corrective Justice and Liability For Increasing Risk*, 37 UCLA L. REV. 439, 450 (1990); see also Richard W. Wright, *Substantive Corrective Justice*, 77 IOWA L. REV. 625, 692 (1992); Catharine P. Wells, *Tort Law as Corrective Justice*, 88 MICH. L. REV. 2348, 2355 (1990) (“[T]he point of corrective justice is to redress unjust gains and losses by means of a financial adjustment.”).

¹⁸⁵ See generally Gary T. Schwartz, *Mixed Theories of Tort Law: Affirming Both Deterrence and Corrective Justice*, 75 TEX. L. REV. 1801 (1997).

¹⁸⁶ See *id.* at 1832.

¹⁸⁷ See generally *id.*

maximization) is whether the benefits of the products or activities exceed the risks posed to potential victims, and this inquiry need not employ or even reflect the moral norms underlying corrective justice.¹⁸⁸ Society as a whole is better off after such an interaction from the standpoint of allocative efficiency if the winner wins more than the loser loses, whether or not the winner's conduct meets some predetermined legal standard of care.¹⁸⁹ The role of compensation is not to correct past wrongs, but to steer private conduct in the direction of an efficient allocation of resources.¹⁹⁰ It is unclear whether this view of the moral irrelevance of the defendant's conduct extends to fraud on a regulatory agency in obtaining access to the marketplace.

The protective justice role of the common law of torts is, of course, very similar to the role that federal regulation plays in protecting citizens from the health and safety risks of the products and activities over which the federal government has authority. When the regulatory system is functioning effectively, it is possible that the two roles overlap to such a degree that the common law protective justice function is unnecessary. If the goal of the regulatory program is to maximize the net benefits of the regulated product (i.e., allocative efficiency) and if the relevant regulatory agency is doing its job, then there is arguably no need for tort law to play its protective justice role. It might, therefore, make sense for Congress to provide that the federal statute preempts state common law claims. In fact, that is precisely what the drug industry, with the strong support of the George W. Bush Administration, argued in the case of prescription drugs.¹⁹¹ This argument, of course, assumes that the common law should no longer be available to perform its corrective justice role of shifting loss from innocent victims to wrongdoers.

If, however, there are good reasons to believe that the regulatory program is not capable, standing alone, of maximizing net benefit to society, then the

¹⁸⁸ See generally *id.*

¹⁸⁹ W. Kip Viscusi, *Overview*, in *REGULATION THROUGH LITIGATION 4–5* (W. Kip Viscusi ed., 2002); see also Schwartz, *supra* note 185, at 1803–06.

¹⁹⁰ It is possible, of course, to imagine a more modest role for protective justice that recognizes the power of the common law to steer private sector conduct in socially desirable directions without limiting that power to the single goal of achieving allocative efficiency. See Schwartz, *supra* note 185, at 1831. See generally Michael D. Green, *Safety as an Element of Pharmaceutical Quality: The Respective Roles of Regulation and Tort Law*, 42 ST. LOUIS U. L.J. 163 (1998). For example, a legitimate protective justice goal might be to achieve a precautionary margin of safety or to attain some degree of wealth redistribution beyond that required by corrective justice, through “spreading the risk” of socially desirable, but risky activities across all of the beneficiaries and victims of those activities.

¹⁹¹ CAROL S. WEISSERT & WILLIAM G. WEISSERT, *GOVERNING HEALTH: THE POLITICS OF HEALTH POLICY* 247 (3d ed. 2006).

common law's protective justice function can serve as a powerful "backstop" to the regulatory program by reinforcing the efforts of the regulatory agency through the added incentive of avoiding tort liability.¹⁹² One area, in particular, in which the federal agency program is not likely to function well is where regulatees are able to "game" the system by providing fraudulent or misleading information to the agency during the regulatory process. The case for federal preemption of state common law claims involving fraud on federal agencies is only valid on its face to the extent that regulatees are convinced that any efforts to defraud the agency will be detected and severely punished. The Ketek case study related above and numerous other examples of successful manipulation of the regulatory process make it abundantly clear that the FDA has not convinced applicants for new drug approval that they will be severely punished for such misconduct. The common law can, therefore, provide a critical supporting role for the FDA's beleaguered new drug approval program, but only if the courts do not discourage plaintiffs from raising manipulative misconduct on the part of drug manufacturers in common law litigation.

C. *Buckman and Federal Preemption of State Fraud-on-the-Agency Claims*

In *Buckman Co. v. Plaintiffs' Legal Committee*,¹⁹³ the Supreme Court first took up the question of the role that state common law may play as a supplement to the FDA's fairly modest efforts to investigate and punish fraud on the agency.¹⁹⁴ That case, however, involved a unique factual setting not at all typical of the many products liability lawsuits involving FDA-approved drugs and medical devices. In the seven intervening years since *Buckman* was decided, some lower courts have carefully limited it to its unique facts, but a few venturesome lower courts have extended *Buckman* to dismiss claims or exclude evidence in factual and procedural contexts in which the *Buckman* Court's reasoning is not apparent.¹⁹⁵ The Supreme Court had an opportunity in 2008 to clarify *Buckman*'s reach when it granted certiorari in *Warner-Lambert Co. v. Kent*,¹⁹⁶ but it resolved the dispute, without addressing the issue, in a

¹⁹² See, e.g., Thomas O. McGarity, *The Regulation-Common Law Feedback Loop in Nonpreemptive Regimes*, in PREEMPTION CHOICE: THE THEORY, LAW, AND REALITY OF FEDERALISM'S CORE QUESTION 235 (William W. Buzbee ed. 2008).

¹⁹³ *Buckman Co. v. Plaintiffs' Legal Comm.*, 531 U.S. 341 (2001).

¹⁹⁴ *Id.*

¹⁹⁵ See discussion *infra* Part II.D.

¹⁹⁶ *Warner-Lambert Co. v. Kent*, 128 S. Ct. 1168 (2008), *aff'g by an equally divided Court* *Desiano v. Warner-Lambert & Co.*, 467 F.3d 85 (2d Cir. 2006).

4–4 affirmance of a lower court holding.¹⁹⁷ The Court will no doubt take up another fraud-on-the-agency case in the not-too-distant future, and it should use that occasion to take advantage of the FDA’s experience with Ketek and similar cases involving clear fraud on the agency—situations in which the only serious consequences to the companies responsible for manipulating the approval process have stemmed from potential tort liability.

1. Buckman’s *Unusual Factual Setting*

In *Buckman*, a class of plaintiffs claimed that its members had suffered lower back injuries after their doctors placed orthopedic bone screws in the pedicles of their spines.¹⁹⁸ They settled their claims against the medical device company that designed and manufactured the offending screws,¹⁹⁹ but they continued to pursue a single claim of rather limited scope against a consulting company that had assisted the manufacturer in obtaining FDA approval of the bone screws.²⁰⁰ The essence of the plaintiffs’ dispute with the consultant was their claim that it had advised and assisted the manufacturer in a coordinated plan to defraud the FDA to gain approval of a device that the FDA clearly would not have approved in the absence of the fraud.²⁰¹ But for the fraudulent misrepresentations made by the manufacturer to the FDA at the consultant’s behest, the plaintiffs argued, they would not have been injured because the agency would never have allowed the devices to be marketed in the first place.²⁰² The plaintiffs argued that under the common law of the various states in which the claims arose, the damage that they suffered to their backs was a but-for consequence of the consultant’s fraudulent manipulation of the FDA regulatory process.²⁰³ The Supreme Court, however, agreed with the defendant-consultant that the plaintiffs’ state common law claims were impliedly preempted by the 1976 Medical Devices Amendments (MDA) to the FDCA.²⁰⁴

¹⁹⁷ *See id.*

¹⁹⁸ *Buckman*, 531 U.S. at 343.

¹⁹⁹ *See* Brief Amicus Curiae of Public Citizen in Support of Respondent at 2, *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341 (2001) (No. 98-1768), 2000 WL 1591269.

²⁰⁰ *Buckman*, 531 U.S. at 343.

²⁰¹ *Id.*

²⁰² *Id.*

²⁰³ *Id.*

²⁰⁴ *Id.* at 344. The court did not need to reach the question of whether the plaintiffs’ claims based on fraud on the FDA were *expressly* preempted by the MDA. *Id.* at 348 n.2.

Under the MDA, no Class III medical devices, a class that included the defendant's bone screws, may be marketed in the United States until the FDA approves it for at least one use.²⁰⁵ To obtain FDA approval, the manufacturer must produce or otherwise reference scientific studies of sufficient scope and quality to provide a "reasonable assurance" that a device is both "safe . . . [and] effective under the conditions of use prescribed, recommended, or suggested in the proposed labeling thereof."²⁰⁶ A "grandfather clause" in the MDA, however, exempts from the premarket approval requirement "predicate" medical devices that were already on the market prior to 1976 and newly manufactured devices that are "substantially equivalent" to such predicate devices.²⁰⁷ The statute prescribes a process, called the § 510(k) process, for obtaining expedited approvals of grandfathered devices, under which the manufacturer must demonstrate that its device is the same as or substantially equivalent to a device that existed prior to 1976.²⁰⁸ As part of this expedited approval process, the manufacturer must certify that it "believes, to the best of [its] knowledge, that all data and information submitted in the premarket notification are truthful and accurate and that no material fact has been omitted."²⁰⁹

The manufacturer's § 510(k) submissions for the bone screws used on the plaintiffs had twice been denied by the FDA's scientific staff on the ground that the screws were not substantially equivalent to spinal screws in existence prior to 1976 and that they posed potential risks not exhibited by other spinal-fixation systems.²¹⁰ The defendant-consultant advised the manufacturer to take one more shot at obtaining expedited approval, but that this time the manufacturer should split the device into its component parts, rename them, and file a separate application for each part.²¹¹ More importantly, the manufacturer should abandon the proposed use in spinal-fixation systems and request approval only for the much less risky use in the long bones of the arms and legs.²¹² Both the manufacturer and the consultant knew full well that doctors would prescribe the screws for spinal-fixation systems, even though

²⁰⁵ 21 U.S.C. § 360e(d)(1)(A).

²⁰⁶ *Id.* §§ 360e(d)(2)(A)–(B); *see also* *Buckman*, 531 U.S. at 344–45 (detailing the requirements of 21 U.S.C. § 360e(c)).

²⁰⁷ 21 U.S.C. §§ 360e(b)(1)(A)–(B).

²⁰⁸ 21 C.F.R. § 807.87(k).

²⁰⁹ *Id.*

²¹⁰ *See* *Buckman*, 531 U.S. at 346.

²¹¹ *See id.*

²¹² *See id.*

that would not be an approved use. The manufacturer would, therefore, reap the economic benefit of a device approved for lower back use without having to convince the agency that it was as safe as other devices that were currently approved for that use.

The manufacturer adopted the recommended strategy and it worked like a charm. This time the FDA approved the bone screws on the ground that they were substantially equivalent to predicate devices used in long bone surgery.²¹³ As anticipated, doctors soon began using the screws for spinal-fixation and the plaintiffs had the screws implanted in their lower backs.²¹⁴ The plaintiffs claimed that but for the consultant's manipulation of the regulatory process, they would not have suffered any injuries because the screws would not have been approved for any use and would not have been available to doctors for the unapproved spinal-fixation use.²¹⁵

2. *The Supreme Court's Rosy Analysis*

The Supreme Court held that the MDA impliedly preempted the plaintiffs' state common law claims.²¹⁶ As an initial matter, the general presumption against preemption, which reflected the "historic primacy of state regulation of matters of health and safety,"²¹⁷ was not applicable to this litigation, because preventing fraud on federal agencies was not a role that the states had traditionally played in protecting the well-being of their citizens. To the contrary, "the relationship between a federal agency and the entity it regulates is inherently federal in character because the relationship originates from, is governed by, and terminates according to federal law."²¹⁸

Absent a presumption against preemption, the Court easily found that the plaintiffs' state common law claims were preempted because they implicitly conflicted with the enforcement role that Congress had assigned to the FDA in the MDA.²¹⁹ The Court understood that it would not be impossible for the defendant-consultant to compensate the plaintiffs for their injuries, while at the

²¹³ See *id.* The agency much later approved the bone screws for use in spinal-fixation systems. See Orthopedic Devices: Classification and Reclassification of Pedicle Screw Spinal Systems, 63 Fed. Reg. 40,025, 40,032 (July 27, 1998) (to be codified at 21 C.F.R. pt. 888).

²¹⁴ See *Buckman*, 531 U.S. at 346–37.

²¹⁵ See *id.* at 343.

²¹⁶ *Id.* at 348.

²¹⁷ *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 485 (1996).

²¹⁸ *Buckman*, 531 U.S. at 347.

²¹⁹ *Id.* at 348.

same time paying a civil or criminal penalty to the federal government for the same fraudulent activity. But it nevertheless found a subtler conflict with the “delicate balance of statutory objectives” that the MDA implicitly empowered the FDA to strike in deciding whether or not to investigate and punish fraud.²²⁰ In particular, the Court identified seven distinct statutory provisions that were “aimed at detecting, deterring, and punishing false statements” made to the agency during the medical device approval process.²²¹ The agency’s flexibility in deciding which, if any, of these tools to employ was “a critical component of the statutory and regulatory framework under which the FDA pursues difficult (and often competing) objectives.”²²² The balance was, in the Court’s view, especially difficult to strike in “regulating the marketing and distribution of medical devices without intruding upon decisions statutorily committed to the discretion of health care professionals.”²²³

The court also identified several statutory policies that could be undermined if private plaintiffs were allowed to base common law claims on fraud on the agency. Such claims could increase the burdens on potential applicants who might “be discouraged from seeking § 510(k) approval of devices with potentially beneficial off-label uses for fear that such use might expose the manufacturer or its associates (such as petitioner) to unpredictable civil liability.”²²⁴ In addition, they could “deter off-label use despite the fact that the [MDA] expressly disclaims any intent to directly regulate the practice of medicine . . . and even though off-label use is generally accepted.”²²⁵ Finally, a common law claim based on fraud on the FDA would “cause applicants to fear that their disclosures to the FDA, although deemed appropriate by the Administration, [would] later be judged insufficient in state court.”²²⁶ Alternatively, massive prophylactic submissions by applicants concerned about state tort liability could tie up the agency and slow down the flow of grandfathered devices, thus impeding competition among predicate devices and delaying health care professionals’ ability to prescribe appropriate off-label uses.²²⁷ The Court’s opinion reflects the agency’s position, set out in

²²⁰ *Id.*

²²¹ *Id.* at 349.

²²² *Id.*

²²³ *Id.* at 350.

²²⁴ *Id.*

²²⁵ *Id.* at 351.

²²⁶ *Id.*

²²⁷ *Id.*

an amicus curiae brief, that state common law claims based on fraud on the FDA were implicitly preempted by the MDA.²²⁸

The Supreme Court in *Buckman* may have focused on the wrong question—the extent to which the plaintiffs’ claim was inconsistent with the government’s undisputed interest in protecting the integrity of the regulatory process by prosecuting attempts to manipulate that process through available federal laws.²²⁹ The plaintiffs in *Buckman* were not attempting to vindicate the federal government’s interest in the integrity of its regulatory process; they wanted to recover damages for injuries caused by a dangerous product that would not have been used but for the defendant’s fraudulent activities. The fact that the particular fraudulent acts that allegedly caused the plaintiffs’ harm were perpetrated on the government, rather than on their doctors or the plaintiffs themselves, was incidental to the plaintiffs’ claim for compensation. State common law has traditionally recognized claims by plaintiffs who have been foreseeably injured through fraud and misrepresentation to third parties, including the government.²³⁰

Although the *Buckman* Court did not identify the factors that weighed into the “delicate balance” that the FDA is supposed to strike in deciding whether to prosecute fraud, an article on the FDA’s enforcement powers written long before *Buckman* was decided, suggests that FDA enforcement officials consider such factors as the seriousness of violations, the level of knowledge or intent, the resources available to agency, and the potential benefit to consumers of successful prosecution.²³¹ Under these criteria, the outcome of the balancing process in the case of fraud on the agency is obvious. Fraud on an agency is a serious offense; the level of knowledge or intent is high; and the potential benefit to consumers of ensuring that the data underlying agency safety determinations is complete and reliable is quite large. The only factor weighing against prosecution is the availability of enforcement resources. The Ketek example demonstrates that lack of resources is a significant limitation, but it is one that common law actions for fraud on the federal agency could

²²⁸ Brief for the United States as Amicus Curiae Supporting Petitioner, *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341 (2001) (No. 98-1768), 2000 WL 1364441.

²²⁹ Thomas O. McGarity, *Beyond Buckman: Wrongful Manipulation of the Regulatory Process in the Law of Torts*, 41 WASHBURN L.J. 549, 550 (2002).

²³⁰ Common law courts have traditionally imposed liability on one who makes misrepresentations contained in documents required by statute to be filed with a government agency; such liability covers damages suffered through justifiable reliance upon the misrepresentation. RESTATEMENT (SECOND) OF TORTS § 536 (1977).

²³¹ Sam D. Fine, *The Philosophy of Enforcement*, 31 FOOD DRUG COSM. L.J. 324, 328–29 (1976).

help alleviate. Thus, concerns about the “delicate balance” involved in exercising the agency’s enforcement discretion are misplaced in the context of fraudulent manipulation of the regulatory process.

Conspicuously absent from the list of relevant considerations is the concern for the economic well-being of the regulated entities. This absence is entirely appropriate given the statute’s obvious focus on safety and efficacy, and the absence of any evidence in the statutory language of any congressional policy favoring government promotion of the drug industry. In the Ketek situation, the agency enforcers at the street level were apparently chomping at the bit to follow up on evidence suggesting that the manufacturer was well aware of the fraud in Study 3014 when it filed its supplementary application for approval to treat sinusitis and chronic bronchitis. Preemption seems far less warranted in cases like Ketek, where strong evidence exists that the agency’s failure to prosecute was motivated as much by solicitation for the drug industry at upper levels of the agency as by a legitimate concern for preserving scarce agency enforcement resources.

3. *Lower Court Extensions of Buckman*

The foregoing analysis argues for limiting *Buckman* to its narrow facts—a claim against a defendant who has helped a regulated entity secure a federal license or allowed it to do so by fraudulently manipulating the permit approval process. The reaction to *Buckman* in the lower courts, however, has been decidedly mixed. Most courts have declined to extend *Buckman* beyond the relatively rare cases in which a plaintiff claims that a drug manufacturer’s fraudulent or misleading statements to the FDA damaged the plaintiff because the drug would not have been on the market had the manufacturer not misled the agency.²³² They have not, for example, extended *Buckman* to cases in which the essence of the plaintiff’s claim is that the manufacturer defrauded or misled the *patient* or the *patient’s doctor*, even though the same conduct may also have misled FDA medical officers during the approval process.²³³

Some lower courts, however, have extended *Buckman* to other contexts in which the Supreme Court’s reasoning is not clearly applicable. The court in

²³² See, e.g., *In re St. Jude Med.*, 2004 WL 45503, at *3 (D. Minn. 2004).

²³³ E.g., *Dawson v. Ciba-Geigy Corp.*, 2001 U.S. Dist. LEXIS 6869 (D.N.J. 2001); see also *Green v. Fund Asset Mgmt., L.P.*, 245 F.3d 214 (3d Cir. 2001) (distinguishing *Buckman* in holding that claims under state “blue sky” securities laws are not preempted by federal securities laws).

Bouchard v. American Home Products Corp.,²³⁴ for example, interpreted *Buckman* to require it to exclude any evidence offered of fraud on the agency to support claims based on negligence, defective product design, and failure to warn—even though the complaint did not include a specific fraud-on-the-agency claim.²³⁵ Similarly, in a case not involving the FDA, the plaintiffs in *Morgan v. Brush Wellman, Inc.* did not argue that the company had defrauded the relevant regulatory agency, which allegedly conspired with the defendant in the alleged negligent activities, but that the company was responsible for the injuries sustained by the workers who were exposed to the undisclosed hazards of beryllium.²³⁶ The court nevertheless found the claims to be preempted because they would conflict with the Department of Energy’s “ability to set nuclear policy consistent with its own judgment and objectives.”²³⁷

The district court in *In re Baycol Products Litigation*²³⁸ sought a middle ground. In that case, a class of plaintiffs attempting to show that the manufacturer of the cholesterol-lowering drug Baycol was responsible for a number of maladies suffered by members of the class offered expert testimony criticizing the company’s submissions to the FDA and the FDA’s approval of the drug.²³⁹ The court held that “to the extent [the expert’s] testimony is offered only to show that the FDA was misled, or that information was intentionally concealed from the FDA, the testimony must be excluded.”²⁴⁰ However, to the extent that it was “offered to support a claim that the medical community, treating physicians or patients were misled by [the manufacturer’s] alleged failure to submit information to the FDA,” the testimony could be admissible based upon the trial court’s determination.²⁴¹

The Supreme Court in 2007 granted certiorari in a case that gave it an opportunity to revisit the scope of the law of fraud-on-the-agency preemption that it had created in *Buckman*. That case, styled *Warner-Lambert Co., LLC v.*

²³⁴ *Bouchard v. Am. Home Prods. Corp.*, 213 F. Supp. 2d 802, 812–13 (N.D. Ohio 2002).

²³⁵ *Id.*; see also *Webster v. Pacesetter, Inc.*, 259 F. Supp. 2d 27, 39 (D.D.C. 2003) (finding that plaintiff’s failure-to-warn claim regarding medical device was preempted insofar as plaintiff argued that the defendant’s failure to adhere to FDA regulations on recordkeeping, labeling, design validation and establishment, and maintenance of complaint file supported the claim).

²³⁶ *Morgan v. Brush Wellman, Inc.*, 165 F. Supp. 2d 704 (E.D. Tenn. 2001).

²³⁷ *Id.* at 722; see also *Nathan Kimmel, Inc. v. DowElanco*, 275 F.3d 1199–1208 (9th Cir. 2001) (holding that claims for tortious interference with prospective business advantage were preempted where plaintiff would be required to prove that defendant committed fraud on the EPA in registering pesticide).

²³⁸ *In re Baycol Prods. Litig.*, 495 F. Supp. 2d 977 (D. Minn. 2007).

²³⁹ *Id.* at 1000.

²⁴⁰ *Id.*

²⁴¹ *Id.*

Kent, was a challenge to a Michigan “liability shield” statute, enacted as part of a larger “tort reform” initiative in that state, that prohibited state courts from entertaining common law claims against manufacturers of FDA-approved drugs.²⁴² In a modest concession to the realities of the FDA drug-and-device approval process, the statute contained an exception allowing the claim to go forward if the plaintiff could establish that the defendant had procured FDA approval by defrauding the agency.²⁴³

In *Kent*, a large number of plaintiffs in Michigan and California sued the manufacturer of the FDA-approved diabetes drug Rezulin.²⁴⁴ The claims in all of the cases were consolidated in a New York federal district court where the defendants asserted the statute as a defense to the Michigan plaintiffs’ claims.²⁴⁵ The plaintiffs responded that their cases came within the exception, and offered to prove that the company had misled the FDA in reporting the results of the clinical trials upon which the agency based its approval.²⁴⁶ A series of articles in the *Los Angeles Times* had reported that in connection with its NDA the company concealed from FDA medical officers information in its possession showing that Rezulin could cause liver damage.²⁴⁷ In addition, when the company submitted a safety update soon after the FDA approved the drug, stating that no patients taking the drug in the clinical trials had liver enzymes in excess of three times the upper limit of normal, the company knew (and later admitted in a letter to the *New England Journal of Medicine*²⁴⁸) that twenty patients in the study had demonstrated elevated enzyme levels. Ultimately, the FDA forced the company to withdraw Rezulin, but one of the medical officers that reviewed the Rezulin application stated that the agency would not have approved the drug in the first place if the agency staff had been privy to the information that the company had withheld.²⁴⁹ Warner-Lambert responded that the fraud exception in the state statute was preempted under *Buckman*.²⁵⁰ Because the liability shield provision, the company argued, was not preempted by any federal law, the plaintiffs’ claims could therefore not

²⁴² Warner-Lambert Co. v. Kent, 128 S. Ct. 1168 (2008).

²⁴³ MICH. COMP. LAWS ANN. § 600.2946(5)(a) (West 2006).

²⁴⁴ Desiano v. Warner-Lambert & Co., 467 F.3d 85, 85 (2d Cir. 2006), *aff’d by an equally divided Court*, Warner-Lambert Co. v. Kent, 128 S. Ct. 1168 (2008).

²⁴⁵ *Id.* at 88.

²⁴⁶ *Id.* at 87.

²⁴⁷ See, e.g., David Willman & Nick Anderson, *Rezulin’s Swift Approval, Slow Removal Raise Issues*, L.A. TIMES, Mar. 23, 2000, at A-1.

²⁴⁸ See David Willman, *Risk Was Known as FDA Okd Fatal Drug*, L.A. TIMES, Mar. 11, 2000, at A-1.

²⁴⁹ Desiano, 467 F.3d at 88.

²⁵⁰ *Id.*

proceed.²⁵¹ The company cited a 2004 Sixth Circuit precedent involving the same Michigan statute that had followed this line of reasoning in all particulars.²⁵²

Explicitly rejecting the Sixth Circuit precedent, the Second Circuit in *Kent* held that the plaintiffs' claims could go forward because they came within the fraud exception to the Michigan law and that the provision was not preempted under *Buckman*.²⁵³ Finding that the plaintiffs' common law claims and the state statute limiting common law liability both addressed matters that had traditionally been regulated by the states, the court applied the presumption against preemption.²⁵⁴ Since FDA approval was relevant only if the defendant elected to assert the Michigan statute as an affirmative defense, the case was not at all like *Buckman*, a case in which the plaintiffs argued that fraud against the FDA, standing alone, was sufficient to impose liability. The court was unwilling to conclude that the Supremacy Clause required common law courts to exclude all evidence of fraud on federal agencies.

Less than a week after hearing oral arguments in the *Kent* appeal, the Supreme Court issued a one-sentence unsigned opinion that affirmed the Second Circuit decision by equally divided 4–4 Court, the Chief Justice having recused himself.²⁵⁵ The unsatisfactory result is that the Michigan plaintiffs in that case (and presumably future cases in which plaintiffs from Michigan and states with similar statutes can locate their cases in the Second Circuit) can continue to pursue their claims against Warner-Lambert, while the plaintiffs in states within the Sixth Circuit continue to occupy the worst of all possible worlds: drug companies are immune from failure-to-warn claims, and the fraud-on-the-FDA exceptions that the legislature added to prevent scofflaws from taking advantage of the immunity are also unavailable.

III. WHY FEDERAL ENFORCEMENT IS NOT ENOUGH

At the core of the Court's implied preemption analysis in *Buckman* is its conclusion that allowing plaintiffs to pursue state common law claims based on fraud on the FDA is inconsistent with the "delicate balance" that Congress empowered the FDA to strike in deciding whether and how to prosecute

²⁵¹ *Id.*

²⁵² *Id.* (citing *Garcia v. Wyeth-Ayerst Labs.*, 385 F.3d 961 (6th Cir. 2004)).

²⁵³ *Id.* at 85.

²⁵⁴ *Id.* at 93–94.

²⁵⁵ *Warner-Lambert Co. v. Kent*, 128 S. Ct. 1168 (2008).

alleged frauds perpetrated upon it by applicants for FDA approvals.²⁵⁶ Because Congress did not expressly preempt such claims (or any other common law claims, for that matter) in the statute itself, the Court had to conclude that Congress, at least implicitly, meant to preempt them when it provided the agency with seven separate statutes for holding scofflaws accountable for their fraudulent activities. This critical conclusion is the weak link in the *Buckman* Court's preemption analysis for at least three reasons. First, once the FDA has failed to detect fraud during the drug approval process (or, as in the case of Ketek, decided to ignore it), it is not in the agency's institutional self-interest to launch a serious investigation into the fraud after the drug has caused injury, or even death, to the very people that Congress has charged the agency with protecting. Second, quite apart from this institutional conflict of interest, the Ketek experience makes painfully clear that the FDA (and other similarly situated agencies) is subject to "capture" by the regulated industries, especially in business-friendly administrations that are anxious to reduce regulatory burdens. Third, the Court's extra-statutory policy analysis stressed the limited resources available to agencies for enforcing the laws for which they are responsible, but ignored the role that state common law could play in expanding the resources available for detecting and punishing fraud perpetrated on the FDA during the drug approval process.

A. *Institutional Conflict of Interest*

When a product licensee has successfully manipulated the regulatory process, the agency has a strong institutional incentive to keep that fact under wraps. The officials charged with managing a licensing regime, like those officials within the FDA approval process, obviously have little interest in revealing to the world that they have been duped and have, therefore, failed in their statutory obligation to protect the public health. Such revelations can only attract harsh criticism from the press and the pundits, and, in the extreme, invite embarrassing congressional oversight. The humiliation suffered by upper-level FDA officials during the Ketek congressional investigations was by no means the first time that FDA officials had to endure the harsh glare of a critical media. Similar revelations involving manipulation of the FDA approval process for the drugs Actonel, Baycol, Rezulin, Vioxx, Xanax, and others have kept the FDA, in the public spotlight throughout the past five

²⁵⁶ See *supra* notes 216–29 and accompanying text (discussing the Supreme Court's analysis of the *Buckman* case).

years.²⁵⁷ Rather than aggressively prosecute a fraudulent company's malfeasance after the fact, thereby tacitly acknowledging the agency's failure to detect the fraud at the critical moment that it approved its product, upper-level agency officials may prefer to sweep the whole sordid matter under the rug with a quiet warning letter.

Private tort claimants, by contrast, do not labor under any such institutional conflict of interest. If a defendant cites an agency's approval of its product or product label as evidence of compliance with the relevant common law standard of care, a plaintiff has every reason to obtain and introduce evidence of fraud on the agency to rebut that argument. Furthermore, evidence of fraud on a regulatory agency can be very impressive to juries concerned about the moral blameworthiness of the defendant's conduct, especially at the time that it evaluates the plaintiff's claim for punitive damages. Plaintiffs' attorneys thus have a powerful pecuniary incentive to ferret out information demonstrating fraudulent manipulation of the regulatory process from agency files, internal company memoranda, and sworn deposition testimony of company employees appearing pursuant to judicially enforceable subpoenas.²⁵⁸ The Supreme Court's *Buckman* opinion, at least as interpreted by some courts, effectively takes these determined bird dogs out of the hunt.

B. Agency Capture

Throughout its long history, the FDA has suffered periodic bouts of "capture" that are characterized by business-friendly regulatory policies, severely reduced enforcement efforts, and the adoption of voluntary measures that enhance the freedom of regulated entities to pursue their economic

²⁵⁷ See THOMAS O. MCGARITY, *THE PREEMPTION WAR* ch. 1 (2008) (Vioxx); THOMAS O. MCGARITY & WENDY A. WAGNER, *BENDING SCIENCE: HOW SPECIAL INTERESTS CORRUPT PUBLIC HEALTH RESEARCH* 37, 72, 73, 85–86, 246–48 (2008) (Actonel, Baycol, Xanax, Rezulin); PETERSEN, *supra* note 19, at 173–77 (Rezulin); Margaret Gilhooley, *Vioxx's History and the Need for Better Procedures and Better Testing*, 37 SETON HALL L. REV. 941 (2007) (Vioxx). See generally David Vladeck, *The FDA and Deference Lost: A Self-Inflicted Wound or the Product of a Wounded Agency? A Response to Professor O'Reilly*, 93 CORNELL L. REV. 981, 997 (2008) (alluding to "a steady drumbeat of headlines critical of [the FDA's] performance").

²⁵⁸ See MICHAEL D. GREEN, *BENEDICTIN AND BIRTH DEFECTS: THE CHALLENGES OF MASS TOXIC SUBSTANCES LITIGATION* 15 (1996) (detailing how attorneys for plaintiffs in asbestos cases obtained information on wrongdoing); Margaret A. Berger, *Eliminating General Causation*, 97 COLUM. L. REV. 2117, 2150 (1997) (citing case studies that "amply demonstrate the legal system's ability to ferret out the 'smoking guns' that would establish negligence"); Richard A. Nagareda, *Turning from Tort to Administration*, 94 MICH. L. REV. 899, 923 (1996) (reporting that plaintiffs' attorneys in the breast implant litigation "invested several million dollars toward the collection and organization of documents bearing upon the defendant manufacturers' knowledge of potential product risks").

interests with minimal government interference.²⁵⁹ Observers of the regulatory process ranging across the political spectrum from Chicago School founder George Stigler to consumer activist (and perennial presidential candidate) Ralph Nader have noted the tendency of most regulatory agencies, at one time or another, to become captured by the industries that they are supposed to regulate.²⁶⁰ In times during which the fox is guarding the chicken coop, enforcement levels tend to fall off dramatically.²⁶¹ Even during periods in which the agency's leadership favors strong regulatory programs and aggressive enforcement actions, it can be very difficult for the agency to maintain a vigilant posture.²⁶² The practical necessity of dealing with representatives from the regulated industry on a day-to-day basis means that the agency cannot constantly antagonize the companies it regulates.²⁶³ The simple rule of bureaucratic life that "you can't go to the mat every time" likewise operates as a serious constraint on an agency's vigor in policing against threats to the integrity of the regulatory process.²⁶⁴

Seriously constrained by limited scientific and enforcement resources and heavily dependent on the regulated entities for the information that they need to do an adequate job, regulatory agencies are inclined to enter into informal arrangements with regulatees under which agency officials "jawbone" with regulatees about data requirements, the validity of scientific studies, and other regulatory issues relevant to individual products.²⁶⁵ These closed-door

²⁵⁹ See HILTS, *supra* note 14, at chs. 2, 8, 14, 19.

²⁶⁰ George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3, 3–5 (1971); see also CHARLES MCCARRY, CITIZEN NADER 217 (1972). See generally PAUL J. QUIRK, INDUSTRY INFLUENCES IN FEDERAL REGULATORY AGENCIES 4–21 (1981); Cass R. Sunstein, *Constitutionalism After the New Deal*, 101 HARV. L. REV. 421, 448–49 (1987). But see David B. Spence, *The Shadow of the Rational Polluter: Rethinking the Role of Rational Actor Models in Environmental Law*, 89 CAL. L. REV. 917 (2001) (criticizing the capture theory as outdated and unsupported by the evidence).

²⁶¹ See ALICIA MUNDY, DISPENSING WITH THE TRUTH: THE VICTIMS, THE DRUG COMPANIES, AND THE DRAMATIC STORY BEHIND THE BATTLE OVER FEN-PHEN 53 (2001) (recounting how FDA officials in the early 1990s spoke of the pharmaceutical industry as "our clients"); James T. O'Reilly, *Losing Deference in the FDA's Second Century: Judicial Review, Politics, and a Diminished Legacy of Expertise*, 93 CORNELL L. REV. 939 (2008). See generally RICHARD A. HARRIS & SIDNEY M. MILKIS, THE POLITICS OF REGULATORY CHANGE: A TALE OF TWO AGENCIES (2d ed. 1996).

²⁶² See Richard B. Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1667, 1684–87 (1975).

²⁶³ See MUNDY, *supra* note 261, at 65 (stating that the FDA office director remarked that agency employees "cannot speak so bluntly to the industry," because "[t]hey are our customers").

²⁶⁴ See generally Clayton P. Gillette & James E. Krier, *Risk, Courts, and Agencies*, 138 U. PA. L. REV. 1027 (1990).

²⁶⁵ See GREEN, *supra* note 256, at 49 (describing the ongoing process of informal communications with the regulated industry that supplements the FDA's formal drug approval process); Thomas O. McGarity,

sessions provide an opportunity for regulatees to argue for less costly (and therefore less protective) approaches to data gathering and regulatory requirements without any countervailing arguments from consumer representatives. From such a position of dependency, the agency can easily become “overwhelmed by the efforts of an industry that is intent on keeping its products on the market.”²⁶⁶

Allowing claims for fraud on the agency to proceed in state courts will by no means eliminate the potential for abuse, but it will send a salutary message to participants in closed door negotiations that the content of such exchanges may be uncovered in future litigation and that regulatees who omit important information or mislead the agency may ultimately be held accountable for their misconduct. In this way, tort law can provide the necessary countervailing pressure on agencies to avoid “sweetheart” deals, in which the agency shirks its regulatory responsibilities. Proponents of preemption may plausibly argue that this sort of deal-making is a desirable vehicle for ensuring the political accountability of agency officials as they engage in the delicate balancing necessary to implement their conception of the agency’s regulatory responsibilities. This limited degree of political accountability, however, can hardly justify fraudulent manipulation of the scientific information upon which the agency bases decisions that are literally a matter of life or death for the beneficiaries of the drug approval process.

C. *Limited Resources*

During the past thirty years of contracting government at the federal level, federal regulatory agencies have generally assigned a low priority to policing the integrity of the regulatory process. While during that period of time Congress has increased the FDA’s responsibilities for administering a growing number of regulatory programs, it has not correspondingly increased agency enforcement budgets.²⁶⁷ The brief periods of public outrage that attend news reports of fraud on federal agencies rarely result in sustained increases in the resources that Congress makes available to the agency to combat that fraud. As we have seen, the Director of the FDA’s DSI told the Senate committee

Politics by Other Means: Law, Science, and Policy in EPA’s Implementation of the Food Quality Protection Act, 53 ADMIN. L. REV. 103, 203 (2001).

²⁶⁶ DAN FAGIN, MARIANNE LAVELLE & THE CENTER FOR PUBLIC INTEGRITY, TOXIC DECEPTION: HOW THE CHEMICAL INDUSTRY MANIPULATES SCIENCE, BENDS THE LAW AND ENDANGERS YOUR HEALTH ix (1996).

²⁶⁷ See HILTS, *supra* note 14, at xv; Vladeck, *supra* note 257.

staff that the “FDA rarely investigates companies because it is a ‘losing game,’ [thus] the chances of getting warning letters was zero.”²⁶⁸

The disparity between Congress’s imposition of regulatory responsibilities and its allocation of resources to meet those responsibilities is especially acute in the case of the FDA.²⁶⁹ In a comprehensive report on the FDA’s administration of the drug approval process initiated in the wake of the Vioxx revelations, a scientific panel assembled by the National Institute of Medicine concluded in 2006 that the FDA “lacks the resources needed to accomplish its large and complex mission today, let alone to position itself for an increasingly challenging future.”²⁷⁰ A survey of almost 1,000 FDA scientists conducted that same year revealed that 70% of those scientists believed that the FDA lacked sufficient resources to protect the public health from the adverse side effects of prescription drugs.²⁷¹ The tiny staff of the FDA’s DSI cannot inspect even a fraction of the clinical investigators in the field. In fiscal year 1999, for example, the FDA inspected only 468 out of more than 14,000 clinical investigators actually conducting trials during that time period.²⁷²

Even the industry recognizes that the “FDA is drowning under the weight of its added responsibilities and its budget woes.”²⁷³ In a November 2007 report to the Subcommittee on Science and Technology of the FDA Science Board, long-time FDA practitioner Peter Barton Hutt concluded that the “FDA has become a paradigmatic example of the ‘hollow government’ syndrome—an agency with expanded responsibilities, stagnant resources, and the consequent inability to implement or enforce its statutory mandates.”²⁷⁴ Exacerbating the problem is the fact that the FDA’s appropriations, for historical reasons, originate not in the health-related appropriations subcommittees, but in the agriculture-related subcommittees, whose priorities

²⁶⁸ Letter, *supra* note 28, at 16–17.

²⁶⁹ See Green, *supra* note 190, at 174 (“The FDA is woefully underfunded for its mandate . . .”); Schwartz, *Prescription Products*, *supra* note 182, at 1387–88; Vladeck, *supra* note 255.

²⁷⁰ FUTURE OF DRUG SAFETY, *supra* note 4, at 194.

²⁷¹ UNION OF CONCERNED SCIENTISTS, VOICES OF SCIENTISTS AT FDA: PROTECTING PUBLIC HEALTH DEPENDS ON INDEPENDENT SCIENCE 2 (2006).

²⁷² OFFICE OF INSPECTOR GENERAL, DEP’T OF HEALTH & HUMAN SERVS., SEMIANNUAL REPORT: APRIL 1, 2000–SEPTEMBER 30, 2000, at 51 (2000), available at <http://www.oig.hhs.gov/publications/docs/semiannual/2000/00fsemi.pdf>.

²⁷³ Diedra Henderson, *Drug Makers Lobby U.S. to Hike FDA Funds*, BOSTON GLOBE, July 13, 2006, at A1.

²⁷⁴ Peter Barton Hutt, *The State of Science at the Food and Drug Administration*, in FDA SCIENCE AND MISSION AT RISK: REPORT OF THE SUBCOMMITTEE ON SCIENCE AND TECHNOLOGY, app. B, at B-1 (2007).

are not necessarily those of the agency or its constituencies.²⁷⁵ The White House has also repeatedly turned a deaf ear on FDA requests for additional funds in the Administration's annual budget.²⁷⁶

With the active encouragement of Congress, the FDA has, in recent years, devoted far more attention to eliminating the heavily advertised, but poorly documented, "drug lag" than it has to reducing the much less visible incidence of fraud during the approval process, despite the obvious threat that such fraud poses to the integrity of the overall drug approval process. The disparity stems from Congress's enactment of the PDUFA in response to loud complaints from the pharmaceutical industry, its allies in academia and the think tanks, and some patient advocacy groups about lengthy approval times for new drugs.²⁷⁷ The new law empowered the FDA to charge "user fees" to offset some of the associated agency expenses, so long as the FDA spending on new drug applications stayed above the 1992 levels, and it set strict performance goals (e.g., a statutory requirement that the agency act on 90% of new drug applications within ten months).²⁷⁸ One result of the agency's intense efforts to get new drugs out the door was a greatly increased incidence of drug withdrawals in subsequent years.²⁷⁹ Because Congress has to some degree regarded the user fees as a substitute for additional appropriations, the agency's resources for investigating fraud in the conduct of clinical trials have correspondingly dwindled. The Department of Health and Human Services' Inspector General has, in recent years, undertaken a number of investigations of FDA and pharmaceutical company oversight of clinical investigations related to drug approvals.²⁸⁰ One report noted that FDA staffers typically do not consider an investigator's past record of compliance with FDA regulations in determining whether to allow the investigator to participate in new clinical studies.²⁸¹

²⁷⁵ *FDA's Drug Approval Process: Up to the Challenge? Hearings Before the S. Comm. on Health, Education, Labor, and Pensions*, 109th Cong. 57 (2005) (statement of Abbey S. Meyers, National Organization for Rare Disorders).

²⁷⁶ Henderson, *supra* note 273.

²⁷⁷ 21 U.S.C. §§ 379(g)–(h) (1992).

²⁷⁸ FUTURE OF DRUG SAFETY, *supra* note 4, at 70–74 & boxes 1.1, 2.1; RENA STEINZOR & MARGARET CLUNE, THE HIDDEN LESSON OF THE VIOXX FIASCO: REVIVING A HOLLOW FDA 13–14, 17 (Center for Progressive Reform White Paper No. 514, Oct. 2005).

²⁷⁹ Thirteen FDA-approved drugs were withdrawn in the four-year period between 1997 and 2001 compared to only ten withdrawals in the twenty-year period between 1974 and 1993. STEINZOR & CLUNE, *supra* note 278, at 17.

²⁸⁰ See OFFICE OF INSPECTOR GENERAL, *supra* note 272.

²⁸¹ *Id.* at 51.

IV. ENHANCING ACCOUNTABILITY BY LIMITING PREEMPTION

The recent congressional hearings on Ketek, Vioxx, and other regulatory failures, coupled with extensive investigative reports in the mainstream media over the past five years, and comprehensive reports from the Government Accountability Office, the Department of Health and Human Service's Office of Inspector General, and the National Institute of Medicine all paint a portrait of an agency that is awash in regulatory responsibilities and unable or unwilling to take the steps necessary to ensure the integrity of the scientific information on which it bases life-or-death decisions about the safety and efficacy of prescription drugs. The added regulatory authority provided by the 2007 Amendments to the FDCA may help the struggling agency to regain its momentum, but only if the upper-level agency leadership is determined to refocus its efforts on its primary function of ensuring the safety and efficacy of new and existing drugs, and only if Congress provides sufficient resources to ensure that the agency is up to the task.²⁸² History teaches that rosy projections for significant improvement, following periods of increased public attention to regulatory failures, and resulting congressional action are often swamped by the realities of day-to-day administration of regulatory programs as the agencies encounter fierce resistance from the regulated industries, endure budgetary stagnation as Congress focuses its attention on other pressing priorities, and eventually become dominated by the very entities that they are charged with overseeing.²⁸³

The FDA and other agencies with similar wide-ranging responsibilities and perennial budgetary restrictions will never have sufficient resources to purge the regulatory system completely of misleading submissions of scientific studies by irresponsible regulated entities. Only following periodic crises in public confidence are they likely to have sufficient resources and political motivation to reduce the level of manipulation to even tolerable levels. The bottom line is that the companies that engage in fraud in their submissions, tolerate fraud when it comes to their attention, or otherwise attempt improperly to "game" the regulatory process will only rarely be held accountable for their

²⁸² The primary House sponsor of the FDCA, Rep. Henry Waxman, remarked, at the time of enactment, that in addition to the additional resources that the statute would make available to the FDA's Office of Surveillance and Epidemiology, the agency "will need a significant influx of resources to do what we are asking them to do," and "it will be critical for Congress to come forward with additional appropriated dollars." 153 CONG. REC. H7602 (2007).

²⁸³ See generally Thomas O. McGarity, *The Expanded Debate over the Future of the Regulatory State*, 63 U. CHI. L. REV. 1463 (1996).

malfeasance if the manipulated regulatory agency is the only institution available to root out and punish such improper behavior.

It is precisely at this point that a fully functional common law tort regime can best complement the regulatory process that shares the common goal of ensuring that patients are adequately protected from the unintended, but inevitable, adverse side-effects of modern pharmaceutical products. The contingency fee agreement provides a powerful economic incentive for plaintiffs' attorneys to uncover fraud in the regulatory process and bring it to the attention of courts, juries, and ultimately, the agencies and the public. When functioning properly, the civil liability system gives pharmaceutical companies an equally powerful economic incentive to provide accurate scientific information to the FDA during the drug approval process, to share information about potential adverse effects of their products with doctors and patients as it becomes available, and to amend the warning labels of prescription drugs to reflect new understandings about their safety and efficacy.

Throughout most of its lengthy history, the FDA has welcomed the added attention that the tort reparations system can devote to the efforts of drug manufacturers to develop and market their products.²⁸⁴ Since the turn of the twenty-first century, however, the agency has aggressively sought out ways to preempt state common law claims, including those based on clear evidence of fraudulent manipulation of the regulatory process.²⁸⁵ To the extent that the courts are willing to give effect to this radical shift in regulatory policy, the added resources and strong incentives that the civil justice system can provide will no longer be available to the agency and to the millions of patients who take their daily prescriptions on the assumption that the FDA is looking out for their interests.²⁸⁶ Even if the agency (perhaps under different leadership) returns to its original position on the preemption question and urges the Supreme Court to allow common law claims based on fraud on the agency to proceed, however, it is highly unlikely that the Supreme Court will overrule *Buckman* any time in the foreseeable future. That opinion is, after all, putatively grounded in a "delicate balance" of *statutory* objectives, and agencies are incapable of changing or rearranging statutory policies.

²⁸⁴ David A. Kessler & David C. Vladeck, *A Critical Examination of the FDA's Efforts to Preempt Failure-to-Warn Claims*, 96 GEO. L.J. 461, 463 (2008).

²⁸⁵ *Id.* at 463–64.

²⁸⁶ *Id.* at 465.

The lower courts can temper the impact of *Buckman* by limiting it to its narrow facts, and the Supreme Court can greatly assist in future litigation that raises the fraud-on-the-agency issue in the context of statutes, like the Michigan statute, or when a lower court improperly excludes evidence of fraud on the agency in a case not involving a claim based on that fraud. Since the split in the circuits on the lawfulness of the fraud exception to the Michigan statute still remains unresolved, the Court may well avail itself of its next opportunity to resolve that issue in the context of the Michigan law or any one of several similar statutes in other states, the validity of which will no doubt be litigated in the near future.

At the end of the day, however, Congress will probably have to resolve this important question by enacting either a generic statute applicable to fraud on all federal agencies or “rifle shot” legislation aimed at particular statutes like the FDCA. Attempts to achieve a generic resolution of the problem will face numerous substantive, procedural, and political obstacles. Substantively, it will be very difficult to craft generic language that is capable of instructing the courts to allow claims based on fraudulent manipulation of the wide variety of regulatory practices and procedures that characterize the extremely diverse mosaic of federal regulation. Any broadly applicable change is likely to yield unintended or even perverse results. Because it will necessarily affect a much broader range of economic interests, generic regulation will attract broader and more intense opposition than rifle shot legislation, thereby reducing the probability of obtaining the magic sixty-vote majority that is needed to overcome a Senate filibuster.

Congress would, therefore, be better advised to begin the process of changing the federal judiciary’s approach to fraud-on-the-agency claims by amending the FDCA to overturn *Buckman* in the context of medical devices and ensure that the courts do not pursue a similar approach in the context of drugs. The easiest way to accomplish this would be for Congress to enact a general “savings clause” applicable to both drugs and medical devices using as a model one or more savings clauses in other statutes that have successfully discouraged federal courts from finding that compliance with regulatory requirements implicitly preempts state common law claims. For example, the Federal Aviation Act contained a savings clause providing that nothing in the statute should be construed to “in any way abridge or alter the remedies now

existing at common law or by statute.”²⁸⁷ A more extensive savings clause in the Occupational Safety and Health Act provides that nothing in the Act

shall be construed to supersede or in any manner affect any workmen’s compensation law or to enlarge or diminish or affect in any other manner the common law or statutory rights, duties, or liabilities of employers and employees under any law with respect to injuries, diseases, or death or employees arising out of, or in the course of, employment.²⁸⁸

In the context of common law claims involving fraud on an agency, the statute might read as follows:

Nothing in this chapter or other federal law shall be construed to diminish, abridge or alter in any way the remedies now existing at common law or by statute to persons suffering damage due to fraud, misrepresentation, or other conduct that may reasonably be anticipated to defraud, manipulate or otherwise mislead the Food and Drug Administration.²⁸⁹

This language would leave the substance of the state law claim that the savings clause preserves to state courts and legislatures, while at the same time protecting the FDA against manipulation to the extent that state law is available to redress harm to the beneficiaries of FDA action caused by such manipulative conduct.

CONCLUSION

The FDA’s failure to investigate and take effective action against the manufacturer of Ketek, in light of the strong warnings that it received from both its own scientists and the CRO’s clinical research associate about the integrity of the data contained in Study 3014, is deeply disturbing to an American public that relies heavily on the FDA to ensure that the drugs that millions of citizens use on a daily basis are safe and effective. When informed by the staffs of the DSI and the OCI of the clear evidence of fraud in the conduct of Study 3014 and of the likelihood that Aventis was aware of at least some aspects of that fraud, the upper-level officials in CDER were content to

²⁸⁷ Federal Aviation Act § 1106, 72 Stat. 731, 798 (1994) (formerly appearing at 49 U.S.C. app. § 1506). For the current version, see 49 U.S.C. § 40120(c) (2000 & Supp. V 2005) (“A remedy under this part is in addition to any other remedies provided by law.”).

²⁸⁸ 29 U.S.C. § 653(b)(4).

²⁸⁹ *Cf. supra* notes 287–88.

exclude Study 3014 from the body of scientific information upon which it explicitly relied in justifying its approval of Aventis's application for sinusitis and chronic bronchitis uses.²⁹⁰ More disturbingly, perhaps, is the fact that upper-level officials in the OCI did not feel compelled to follow up on the concerns and recommendations of its highly regarded Special Agent in Charge, a long-time OCI investigator, who the Director of the OCI characterized in internal e-mails as "world class."²⁹¹ The Director forwarded the Special Agent's e-mails to the Associate Commissioner for Regulatory Affairs, who would have been responsible for launching a further investigation through either the OCI or the DSI, and he later told the Senate committee staff that he "assumed" that further action would be forthcoming.²⁹² However, he did not do anything by way of follow up.²⁹³ The agency belatedly initiated a criminal investigation in 2006, but closed the file soon thereafter with a warning letter.

The FDA's failure had serious consequences. The FDA employee who served as both the primary safety reviewer and the safety team leader for Ketek at the time the agency approved it testified to a House oversight committee that the irresponsible behavior of upper-level FDA officials was significant:

Why does Ketek matter? Because FDA broke its own rules and allowed Ketek on the market; because dozens of patients have died or suffered needlessly; because FDA allowed Ketek's maker to experiment with it on children over reviewers' protests; because FDA ignored warnings about fraud; and because FDA used data it knew was false to reassure the public about Ketek's safety.²⁹⁴

At least six people suffered serious liver damage as a result of taking Ketek, but the company responsible for causing that harm got off with a warning letter because upper-level agency officials were unwilling or felt unable to follow the advice of the agency's criminal investigatory staff. Senator Grassley summarized the results of the extensive investigation of the Senate Finance Committee staff as follows: "In the case of Study 3014, there were sirens, red flags and bull horns, but it looks like the company and the FDA kept ear plugs and blinders on."²⁹⁵ Worst of all, to the extent that any litigation by the injured patients relies upon Aventis's conduct in failing to

²⁹⁰ Letter, *supra* note 28, at 18.

²⁹¹ *Id.* (quoting internal e-mail).

²⁹² *Id.*

²⁹³ *Id.*

²⁹⁴ *The Adequacy of FDA*, *supra* note 18, at 136 (statement of Ross) (footnotes omitted).

²⁹⁵ Grassley, *supra* note 78, at 4.

report what it knew to the agency, it is entirely possible that a court will exclude that evidence under *Buckman*.

The Ketek story therefore contains an important lesson for the ongoing litigation over the extent to which drug company submissions of fraudulent or misleading scientific data to the FDA in support of their products should play a role in products liability actions in state and federal courts. The Director of the DSI told the Senate committee staff that “FDA rarely investigates companies because it is a ‘losing game,’ [thus] the chances of getting warning letters was zero.”²⁹⁶ If that is in fact the case, then the Supreme Court of the United States based its conclusion in *Buckman* on an erroneous premise. The Court correctly observed that “the statutory scheme amply empowers the FDA to punish and deter fraud against the Administration,”²⁹⁷ but it did not inquire into whether the agency was willing and able to use that power for the purpose for which Congress granted it. The Ketek experience indicates that the agency’s current leadership does not have much stomach for exercising its enforcement authorities aggressively. Even in less business-friendly administrations, the agency is likely to lack sufficient resources to police against fraud to the extent necessary to protect the public.

If manufacturers face little risk of increased tort liability to patients damaged by prescription drugs when they commit fraud in securing FDA approval, they are quite likely to escape any accountability whatsoever for their malfeasance. Aventis’s President for Research and Development admitted that “Aventis could have been more proactive in bringing the issues encountered at high-enrolling sites, and particularly the highest enrolling site, to the attention of the Agency so it could have used its superior knowledge and investigative tools to evaluate the potential for fraud at an earlier point.”²⁹⁸ The company could have, and should have, been considerably more attentive to its statutory duty to report evidence of fraud to the FDA and its common law duty to protect innocent patients from a product that to its knowledge posed risks of an unknown magnitude to their health, either by restricting patients’ access to the drug or warning their doctors of the doubtful integrity of the scientific data underlying the FDA’s assessment.

Although the principal investigator who was immediately responsible for the fraud spent fifty-seven months in prison, and although the FDA did very

²⁹⁶ Letter, *supra* note 28, at 16–17.

²⁹⁷ *Buckman Co. v. Plaintiffs’ Legal Comm.*, 531 U.S. 341, 348 (2001).

²⁹⁸ Chew, *supra* note 71, at 10.

belatedly launch a criminal investigation into Aventis's misconduct, the company that was ultimately responsible for the integrity of the data on which it secured the FDA's approval did not even pay a modest civil penalty for misleading the agency. If the courts interpret *Buckman* broadly, as some already have, to bar evidence of fraud on the FDA from common law products liability actions, the company will have received a free pass from the federal government to collect \$400 million for a drug taken by thousands of children to reduce earaches and similar relatively minor symptoms associated with common sinus infections, knowing full well that the drug was capable of causing liver damage, heart disease, and vision impairment in some of those patients. To ensure that drug and device manufacturers adhere to their data integrity responsibilities and are held accountable when they do not, the courts should limit *Buckman* to its narrow facts. Failing that, Congress should amend the FDCA to overturn *Buckman* and allow the common law courts to impose liability on companies that wrongfully manipulate the drug and device approval process.

