DRUG REVIEW “BEHIND THE CURTAIN”:
A RESPONSE TO PROFESSOR STRUVE

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INTRODUCTION

The architecture of accident compensation does not mesh well with the architecture of regulatory product approval. Accident compensation, which occurs through public jury trials, is overtly adversarial and virtually transparent. In contrast, regulatory product approval,1 which occurs through specific negotiation between the product sponsor and the regulatory body, is cooperative and consciously opaque.2 Indeed, the content of regulatory negotiations remains hidden behind the curtain, shrouded in confidentiality rationales.3 Consequently, giving regulators a potentially determinative say in tort suits is highly problematic.

A decade-old debate is raging in product liability law over the proper role of Food and Drug Administration (FDA) approval of prescription drug designs and attendant warnings. Participants disagree about whether such approval establishes a “floor” or a “ceiling” that limits the sponsor’s duty of care.4 Into this debate steps Professor Catherine Struve, whose excellent article5 offers wall-to-wall coverage of the primary jurisdiction doctrine. Traditionally, regulatory product approval has set a floor, which is a minimum level for the sponsor’s duty of care.6 Accordingly, courts or juries in tort cases could find

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2 Details of negotiations are not publicly disclosed to protect the confidentiality of product sponsors. See 5 U.S.C. § 552(b)(4) (2000) (excluding trade secrets from public reporting requirements of federal agencies); see also 21 C.F.R. § 314.430(b) (2007) (barring the FDA from publicly disclosing a drug application until an approval letter has been sent to the drug sponsor).

3 For example, Freedom of Information Act exemptions are available to the FDA. See 5 U.S.C. § 552(b)(3)–(5) (2000); see also 1 JAMES T. O’REILLY, FEDERAL INFORMATION DISCLOSURE § 14:93 (3d ed. Supp. 2007).

4 See, e.g., W. Kip Viscusi et. al., Deterring Inefficient Pharmaceutical Litigation, 24 SETON HALL L. REV. 1437, 1478–79 (1994) (arguing that approval should establish a ceiling on manufacturers’ duty of care).


6 See RESTATMENT (THIRD) OF PRODUCTS LIABILITY § 4(b) cmt. e (1998); RESTATEMENT (SECOND) OF TORTS § 288C (1965) (“Compliance with . . . an administrative regulation does not prevent a finding of negligence where a reasonable man would take

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that reasonable care requires drug makers to use safer ingredients, additional warnings, or more stringent controls. Courts have permis-
sibly imposed such heightened duties of care for decades while the FDA has been reluctant to take sides. But recently, as Professor Struve notes, the FDA has viewed its approval as creating a ceiling with its sharp swing toward supporting the preemption doctrine, which interposes a defense for drug makers whose drugs have received FDA approval.

Support for implied preemption appears to be in fashion among conservative political leaders because it can extinguish liability suits. Bush Administration appointees include recent FDA Commissioners Andrew von Eschenbach and Mark McClellan—both Bush supporters from Texas—as well as conservative FDA counsel. These and other Bush appointees have led to a shift in FDA policy, which now supports the implied preemption doctrine. Yet, despite this shift, drug industry advocates have failed to persuade skeptical
judges to adopt the doctrine. Consequently, drug industry advocates have now turned their support to an approach based on primary jurisdiction, which Professor Struve discusses in her article. Professor Struve prudently avoids embracing these advocates’ positions.

CONSTITUTIONAL AND PRACTICAL DIMENSIONS

I concur with Professor Struve’s thorough review of the constitutional issues surrounding primary jurisdiction. There has been ample writing on the Seventh Amendment issues and on the constitutional conflicts that arise in preemption cases, and she admirably covers the cases in the field. Professor Struve constructs hypothetical legislation as a helpful paradigm for evaluating the agency’s role in the context of jury trials. Her analysis is an interesting exercise in what-if legislating. Realists, however, would observe that many congressional decision makers were once state legislators and thus likely remain opposed to federal bureaucrats preempting state remedies. This opposition may well be one reason why Congress has never expressly adopted the preemption doctrine. Indeed, opposition on the part of Congress and the plaintiffs’ bar combines to make the discussion of such legislation hypothetical, not imminent.

But beyond Professor Struve’s exploration of the constitutional issues surrounding what could be done are the practical constraints on what should be done. No drug or medical device can be perfectly risk-free. Even worse, some have extensive, serious risks of harm that manufacturers understate or improperly explain to prescribing physicians. Consequently, some patients will inevitably become victims of unreasonably harmful or badly-prescribed drugs and medical devices. And of course, some of those victims will ultimately seek compensation.


15 See Struve, supra note 5.

16 See id.


18 See Struve, supra note 5, at 1064–66.


21 The classic description in tort law is that some prescription drugs are “unavoidably unsafe.” RESTATEMENT (SECOND) OF TORTS § 402A cmt. k (1965). If such drugs have a net social benefit and appropriate warning labels, however, they can be sold on the market without the seller being held strictly liable for the resulting harm. Id.
The Bush Administration policy supporting preemption is as much about economic loss shifting as it is about politics. Precluding compensation to victims decreases drug sponsors’ insurance costs,\textsuperscript{22} and thus increases the potential profitability of engaging in the high-risk quest of making novel, effective drugs. Absolute bars to recovery in tort claims involving FDA-approved drugs and medical devices, through preemption, would save hundreds of millions of dollars in transaction costs including insurance and legal fees. Congress surely recognizes this economic loss shifting, and yet—despite the efforts of drug industry lobbyists\textsuperscript{23}—Congress has declined to expressly preempt state tort actions involving prescription drugs in the same manner as it has preempted similar actions involving nonprescription drugs.\textsuperscript{24}

**THE HYPOTHETICAL LEGISLATION**

Professor Struve addresses hypothetical legislation that would define an additional task for the FDA, namely, acting as the “primary jurisdiction” gatekeeper for tort suits involving drug and medical devices.\textsuperscript{25} In a procedure analogous to those created under state laws, which compel medical screening boards to review malpractice claims initially, a plaintiff would have to wait while the drug label or design at issue was referred “to the FDA for a non-binding advisory determination.”\textsuperscript{26} Presumably, a drug sponsor would gain a great advantage if the FDA found that sponsor’s product reasonably formulated or that sponsor’s label appropriate.

The problem with this hypothetical legislation is that it is hard to imagine an FDA determination that would not favor the defendant, because the FDA previously approved the drug, device, or label at issue. An FDA bureaucrat would implicitly admit failure by formally blessing a lawsuit that alleges that an FDA-approved drug or device was unsafe or inadequately labeled. The likelihood that a highly politicized FDA management would support plaintiffs in product liability actions during a conservative administration is minimal. And even under a more liberal administration, bureaucratic self-esteem is

\textsuperscript{22} It decreases insurance costs by decreasing the demand for products liability insurance. This demand shift, however, likely lags behind the creation of new legislative shields, as pre-enactment injuries would continue to be litigated for several years. Industry advocates successfully lobbied for new legislation in Ohio in 2005, but decreases in insurance costs did not occur immediately upon enactment. See generally James O’Reilly, 2005 Ohio Tort Reform 23–28 (2005) (describing the reforms).

\textsuperscript{23} See, e.g., Bograd, supra note 20, at 20.


\textsuperscript{25} See Struve, supra note 5, at 1064–66.

\textsuperscript{26} Id. at 1064.
so great that the FDA would still probably decline to support plaintiffs, because supporting plaintiffs would be supporting claims contrary to
the prior approval of bureaucratic peers.

The hypothetical legislation creates a new form of adjudication
that transforms the FDA from the gatekeeper of product approval into
the gatekeeper of private tort actions. Why would the FDA concede
weakness in its own approval process, which allowed such products
and labels into the market in the first place? Furthermore, the lives of
plaintiffs and FDA regulators likely intersect only once, whereas the
lives of defendant manufacturers and FDA regulators intersect repeat-
edly. And the "critical path" process will move FDA regulators and
defendant manufacturers even closer together through Reagan-Udall
Institute research grants. Moreover, users of the "revolving door,"
which has led FDA counsels and other leaders to move in and out of
the ranks of drug industry advocates, would be directly offended by
decisions supporting plaintiffs' claims that a drug or device was unsafe
or inadequately labeled.

**Erroneous Assumptions**

Professor Struve's enlightening article makes several important
points that will help courts navigate this swamp of uncharted territory.
I agree with her that FDA approval is "at most, prima facie evidence"
of a drug's safety, but I am even more skeptical than she is about the
wisdom of foreclosing jury review of tort claims involving prescription
drugs and medical devices. The primary jurisdiction doctrine is
flawed because it is based on the same erroneous assumptions about
the FDA approval process that underlie parallel arguments for the
preemption doctrine—arguments that drug industry advocates have
pressed during the current Bush Administration.

Indeed, the primary jurisdiction doctrine suffers the same flaws as
the preemption doctrine, which I address elsewhere in this issue. In
the climax of a classic motion picture, the Wizard of Oz spoke to

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27 See id.
28 Food and Drug Administration Amendments Act of 2007, Pub. L. No. 110-85,
§ 770, 121 Stat. 825, 891 (to be codified at 21 U.S.C. § 379dd). The Reagan-Udall Founda-
tion, created by statute, provides for collaborative research opportunities between the FDA
and drug companies. See id. Commentators have criticized the venture, as they remain
suspicious of the agency working closely with those that it is meant to regulate. See, e.g.,
Richard A. Miller, *Innovating the FDA—With the Drug Industry's Help?*, HUFFINGTON POST,
with_b_72490.html (identifying criticisms of the program but ultimately supporting it).
29 See Troy, supra note 11, at 106 n.4. R
Struve, supra note 5, at 1049.
230, 273–74 (E.D.N.Y. 2007); see also Bograd, supra note 20, at 30.
32 See generally O'Reilly, supra note 8, at Part XIII.
frightened pilgrims in a booming voice, accompanied by smoke and majesty. But when the heroine’s dog unveiled a small, old man manipulating the mechanical image from behind a curtain, Oz’s booming voice warned, “Pay no attention to that man behind the curtain!”\[^{33}\] In the same way, the defense bar, in search of a preemption defense,\[^{34}\] has urged courts to defer to the FDA review process and to pay no attention to its hidden weaknesses. Importantly, the preemption defense can leave injured consumers without any recourse. If a plaintiff claims that the FDA overlooked the flaws in a drug, the defendant responds that primary jurisdiction requires deference to the initial FDA approval. And if the plaintiff claims that the FDA was misled when it issued its initial approval, the defendant responds by citing the Supreme Court’s decision in *Buckman Co. v. Plaintiffs’ Legal Committee*\[^{35}\] to bar any recourse. Checkmate!

**Imperfections of the Approval Process**

Ironically, the drug industry has spun around from its years of opposition to FDA regulatory decisions, recently asserting that the new drug approval process is pure and deserving of deference, now that approval is a potential defense in medical tort cases.\[^{36}\] Studies,\[^{37}\] congressional reports,\[^{38}\] and news coverage,\[^{39}\] however, have shown that the prescription drug approval process is imperfect and quite susceptible to influence, leading to drug approval based on questionable efficacy claims. This showing undermines the drug industry’s assertion that the new approval process is pure and deserving of deference.

\[^{33}\] *The Wizard of Oz* (Warner Bros. 1939).

\[^{34}\] See, e.g., Troy, supra note 11, at 106 n.4.

\[^{35}\] 531 U.S. 341 (2001). Under *Buckman*, federal law preempts a plaintiff’s state tort claim if the plaintiff asserts that the FDA was misled. See id. at 348.

\[^{36}\] Prior to current preemption assertions, drug defendants opposed the deferential acceptance of FDA drug application decisions. See, e.g., Am. Cyanamid Corp. v. FDA, 606 F.2d 1307, 1323–24 (D.C. Cir. 1979).


Moreover, it makes the drug industry seem Oz-like, given its aversion to allowing plaintiffs to reveal the behind-the-curtain claims that led to approval, instead hoping to reveal only the booming voice of the approval decision.

Experienced skeptics will object to the suggestion that primary jurisdiction somehow permits the FDA to “intermediate” tort claims, just as they have loudly objected to the preemption doctrine. Such skeptics might point out that current time limits on reviews and certain intra-agency incentives have strengthened the drug industry’s influence over the drug approval decision. The new 2007 Reagan-Udall Institute process further strengthens this influence. And the drug industry has now gained influence over critical FDA post-approval remedy decisions, such as whether to require additional warnings and restraints on the distribution and prescription of newly approved drugs.

I applaud Professor Struve’s recommendation for a greater evidentiary exposition of the FDA, which would allow juries to weigh some of the weaknesses in the approval process. This would certainly be an improvement. Yet, despite the benefits inherent in Professor Struve’s proposal, a better recommendation would be to make no change at all. As is the case in most other product liability contexts, the current approach allows juries to weigh all of the competing factual and opinion evidence.

WHAT REALLY OCCURS

Under Professor Struve’s hypothetical legislation, a plaintiff faces “dismissal of the claim as a matter of law if the plaintiff failed to present evidence to rebut an FDA finding in the defense’s favor on safety or causa-

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41 Reviewer incentives inside the FDA Center for Drug Evaluation and Research tend to favor approval without recycling the application—i.e., without making further demands for data from the drug sponsor. This ensures that the reviewer can satisfy the specified time periods for application clearance under the Prescription Drug User Fee Act. Reviewers are hesitant to recycle an application because of "strong criticism the agency has received for prolonged review times." See CTR. FOR D RUG E VAL. & R ESEARCH, NEW D RUG GUIDANCE D OCUMENT: R EFUSAL TO  F ILE 2 (1993), available at http://www.fda.gov/cder/guidance/rtf.pdf.


43 Negotiations between the FDA and drug sponsors are vulnerable to legislative provisions that have increased the sponsor’s ability to argue against additional testing requirements. See § 104, 121 Stat. at 832. Recent amendments to the drug application process produced more favorable terms for the industry in the negotiation of new drug advertising claims. See id.
tion.”44 This would be a novel adjudication45 in which the FDA would likely struggle to decide the cause of death or illness in the time allotted. Of course, causation is fact-specific. And the vast majority of reports to official databases such as MedWatch and the Manufacturer and User Facility Device Experience (MAUDE) are unwieldy and unfiltered narrative paragraphs, or forms.46 In most cases, these reports do not lead the FDA to dispatch a local inspector, and a physician specializing in pathology or disease causation rarely assesses the plaintiff’s medical records.

The typical person files a MedWatch report to the FDA without substantive interaction with the agency. Indeed, the FDA remains passive if the reporting person marks “Product Use Error” or “Product Problem” in Box B-1 on FDA Form 3500.47 Under the primary jurisdiction doctrine, only after a plaintiff files suit—perhaps as long as twelve to twenty-four months after injury and six to twelve months after the court processes the initial pleadings—would the district court formally refer the case to the FDA. Presumably, the FDA would then have several months to respond.

**Funding the Cold Case Squad**

The hypothetical legislation sets up a new process of adjudication by the FDA. A “cold case squad” of FDA physicians would try to determine the causation of the plaintiffs’ injuries from MedWatch narratives or the MAUDE database files. To perform this new process of adjudication, the FDA would require more funding for field office staff, more funding for specialists, and more funding for a dedicated expert team to examine MedWatch entries from several years before the initial FDA finding. This would result in three separate versions of causation: the plaintiff’s, the defense’s, and the FDA’s—the latter being the least funded and least timely of the three.

44 Struve, supra note 5, at 1066 (emphasis added).

45 Under the Administrative Procedure Act, this is an “adjudication” because it is a fact-specific determination concerning specific persons’ injuries. See 5 U.S.C. § 551(1) (2000).

46 MedWatch and Manufacturer and User Facility Device Experience (MAUDE) are the principal FDA databases for reporting adverse health effects of drugs and medical devices. MedWatch, which gathers reports from doctors and patients and disseminates important safety information through its website, is available at http://www.fda.gov/medwatch/index.html (last visited Apr. 10, 2008). MAUDE, which contains voluntary facility, distributor, and manufacturer reports involving medical devices, is available at http://www.fda.gov/cdrh/maude.html (last visited Apr. 10, 2008).

THE HUMAN AND OPPORTUNITY COSTS

We must consider the human consequences of investing substantial FDA reviewer time and field inspector resources to produce a finding that would most likely favor the defendant manufacturer. Under the above scenario, the injured party must either go uncompensated and bear the loss or survive on government disability payments (which the government can never recoup from the accused tortfeasor). Although the defendants and defense counsel profit, the plaintiffs’ counsel—likely working for a contingency fee—go unpaid, and are therefore deterred from pursuing future drug cases.

We must also consider the opportunity costs. For example, every dollar that the FDA spends on saving a defendant from facing a jury trial is another dollar that the FDA is not able to spend on application or labeling review for new drug products. Moreover, the Administrative Procedure Act might allow plaintiffs to appeal for injunctive relief from FDA findings, further draining FDA resources.

THE LESSER OF TWO EVILS

Primary jurisdiction, like implied preemption, limits the ability of drug and device victims to obtain tort compensation. Nonetheless, primary jurisdiction is a kinder, gentler version of preemption. Instead of an abrupt preemptive strike that absolutely prohibits compensation, primary jurisdiction is an affirmative defense that allows for judicial balancing. Professor Struve’s hypothetical legislation allows the trial judge to hear both sides argue about the primacy of the FDA’s opinions on the safety of a drug or medical device, and the product’s causal relationship to the plaintiff’s injury. The judge can then opt to defer to the “primary” wisdom of the FDA, which might result in dismissal. Alternatively, the judge could opt to let the jury hear the FDA’s safety and causation opinion.

When making key decisions on primary jurisdiction claims during a drug tort case, the judge should decide whether the FDA made its initial approval decision with as much information as is available during trial. Thus, the judge’s decision should allow for civil discovery of the defendant’s medical knowledge before and after FDA approval. Discovery could reveal evidence of drug safety doubts within the con-

48 See supra notes 26–29 and accompanying text.
50 See supra notes 10–16, 26–27 and accompanying text.
51 See supra notes 9, 25–26 and accompanying text.
52 See Struve, supra note 5, at 1066.
53 See id.
54 See id.
tract research organization, the hospital that housed the clinical study, the manufacturer itself, or inside the medical community. Allowing the jury to hear such doubts and the defendant’s responses to them would more justly resolve tort disputes than giving the defense a preemptive strike with every FDA approval letter.

**WHAT EXPERIENCE TEACHES**

Decades of experience with many federal agencies teaches that, when a judge asks, an agency will invariably assert that regulatory approval sufficiently assures the public of the adequacy of the regulated product. When drug industry counsel asserts the primary jurisdiction defense, the trial judge should keep in mind that the defendant’s approval negotiations with the FDA preceded the injury by several years. Thus, the scientific knowledge about the risks of that drug will likely have improved by the time of trial.

Delay is inherent to the system of drug products liability. Prescribing physicians usually provide data on the adverse effects of drugs and devices to the product sponsor before they provide them to the FDA. So too, sponsors likely pay much closer attention to the marketplace experience of their drug than the actual capability of the FDA reviewing division. If the sponsor consciously misleads the FDA or selectively shares safety data with the FDA, the agency might in rare cases charge fraud; however, courts have not permitted plaintiffs to use claims of fraud on the FDA to support their cause of action.

**NEGOTIATIONS LEAD TO APPROVAL.**

The fallacy that underlies the preemption debate is that all drug approvals reflect a measured scientific evaluation. But veterans of the system will confess that approval of specific drugs often results from great advocacy and only modest data. For example, well-argued, persistent efforts to gain approval might move the Office of Drug Evaluation to sign off on a drug, even over objections from re-

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57. Elsewhere in this issue, I dissect the controversial attempt of the drug industry to stretch the limits of the implied preemption doctrine during the current Bush Administration. See O’Reilly, supra note 8, at Part III.

58. I am not suggesting that the FDA routinely approves bad drugs. Rather, I am suggesting that, based on my observations during more than three decades working with the FDA review process, advocacy is a very important factor in drug approval—perhaps even more important than the sufficiency of data in support of clinical testing end points.
viewers in the specialized drug review divisions. Although records of this are discoverable, they are often exempt from public disclosure. Thus, the public generally sees only the Wizard side of the Oz-like FDA, not the FDA action behind the curtain that actually led to approval.

Some preemption advocates seem to view the FDA’s new drug approval process as analogous to the religious rituals for conferring sainthood inside the Vatican. To knowledgeable observers of the FDA, however, the negotiation of a new drug application (NDA) is every bit as subjective and eclectic as any governmental choice can be. Before the government building security upgrades of the last decade, “hall-walker” representatives from the several major drug companies had easy access to the offices of drug reviewers. At lunch and dinner conversations, drug company representatives and drug reviewers debated the need for greater efficacy proofs, and final label approval was as much an art of negotiation as it was a science of clinical data analysis. The hall-walker “won” when the drug company received the final approval letter, which allowed it to immediately ship the stockpiled product filling its warehouses into the waiting distribution channels of the market. The bribery and fraud cases of FDA drug approvals in 1989, however, ultimately led to the establishment of a more formalized system of drug sponsor and drug reviewer interactions.

That said, there is a procedural benefit to Professor Struve’s proposed system. Preemption advocates have sometimes naively assumed that the motives behind NDA reviewer actions were pure, not even allowing for a hearing to examine the initial approval. In contrast, primary jurisdiction advocates would at least allow for a hearing at which opponents could expose the realities of the initial approval.


60 See 21 C.F.R. § 314.430(g) (2007) (listing data and information that is unavailable for public disclosure).

61 See 21 C.F.R. § 314.105(d) (stating that one cannot introduce a drug into interstate commerce without first receiving an approval letter).

62 In 1994, prosecutors obtained nine guilty pleas and a tenth conviction after investigators discovered that FDA reviewers had received cash in return for approval actions. See Prison Term for Inspector in Bribe Case, N.Y. Times, Dec. 18, 1994, at A55. In response, FDA leaders committed to strengthen the ethical conduct of the review process. See David A. Kessler, Remarks by the Commissioner of Food and Drugs, 50 Food & Drug L.J. 327, 327 (1995) (stressing his duty to “rebuild the agency’s credibility after the generic drug scandal”); Louis W. Sullivan, Remarks by the Secretary of Health and Human Services at the Food and Drug Law Institute’s 33rd Annual Educational Conference, 45 Food Drug Cosm. L.J. 1, 4 (1990) (“I am . . . troubled by the revelation of illegalities [that] threaten to compromise the integrity of the FDA. . . . I will not tolerate bribery, fraud, or other illegalities or improprieties.”).
before a judge could find the approval process sufficient and hold that the plaintiff’s claim was preempted.

**Gatekeeper Roles**

Primary jurisdiction has as its core the displacement of juries’ opinions on the adequate safety of drugs with judges’ acceptance of FDA scientific assessments of product risks and benefits. The societal choice reflected in the 1938 Act and its several amendments was that there should be a technical gatekeeper to evaluate drug company submissions. But as the FDA’s drug review process has become more complex, the Act has required increasingly more skilled reviewers than Congress has been willing to fund. This problem led to the Prescription Drug User Fee Act of 1992 (PDUFA). While the shortage of personnel and expertise has improved somewhat in the post-PDUFA era, FDA review is still not the idealized calculus of pure science that outsiders might presume.

Consider what juries and expert witnesses see in the exhibits at a drug tort trial. The incentive for a plaintiff to prevail on a failure-to-warn claim drives an extensive presentation about adverse data in the NDA file. But even by the time of the plaintiff’s injury, which is often years after the drug was marketed, all relevant data on the drug still may not have reached the FDA. And the plaintiff’s experts, who may once have been drug review officials inside the FDA, might opine to the jury about the relevance of the unreported information to the decision process as a whole. Finally, the defendant is free to blast back against the plaintiff’s aggressive search for records.

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64 For the historical background of the 1938 Act’s gatekeeper role, see 1 James T. O’Reilly, Food and Drug Administration §§ 3:4, 13:2 (3d ed. 2007).
65 See Gardiner Harris, For F.D.A., a Major Backlog Overseas, N.Y. Times, Jan. 29, 2008, at A15 (“In the last 14 years, the drug agency has lost 1,311 employees and nearly $300 million in appropriations to inflation while Congress has passed more than 100 laws defining or expanding its regulatory responsibilities.”).
67 Much of the failure-to-warn litigation relates to the gap between the time of the defendant’s notice of the risk and the time that the defendant communicated the risk to prescribing physicians. See James M. Beck & Anthony Vale, Drug and Medical Device Product Liability Deskbook § 2.04[1] (2004).
68 The 2007 amendments to the PDUFA may, however, improve the quantity and timeliness of incoming risk reports. See Prescription Drug User Fee Amendments of 2007, Pub. L. No. 110-85, 121 Stat. 823, 825 (2007) (amending 21 U.S.C. §§ 379g–379h (2000)) (expanding the duty to provide adequate post-marketing information about drugs). In addition, the parties could find more of the data on post-approval experiences by searching company and contractor files obtained in civil discovery.
DISCOVERY IS BETTER THAN VOLUNTARY SUBMISSIONS

Overall, the expensive, messy, and difficult process of civil discovery does a better job of uncovering flaws in drug approval decisions than does the FDA’s time-sensitive drug review process. Contingency-fee arrangements give the plaintiff’s attorneys direct incentives to discover facts relevant to causation: if the manufacturer did not cause the plaintiff’s injury, then the plaintiff’s attorney will not want to pursue the claim because it has a high risk of nonpayment.

Conversely, in the FDA process, reviewers have an incentive to act quickly\(^69\) and, as a result, a disincentive to find flaws and identify shortcomings in drug applications. Moreover, the applicant’s funds ultimately pay for the FDA drug reviewer’s salary, albeit indirectly via the wizardry of federal accounting practices.\(^70\) For example, the FDA ties the individual reviewer’s rewards to the “productivity” of review and approval\(^71\)—potentially creating a great conflict of interest. In the current climate of faster clearance times, FDA reviewers have a disincentive to criticize drug industry data presentations.

Moreover, plaintiffs have an incentive to use experts to find the flaws in a new drug application even though the FDA may have missed them. With these contrasting incentives in mind, I question why the courts would use a doctrine like preemption or primary jurisdiction to lessen the jury’s role in determining the adequacy of warnings.


\(^71\) Critics of the PDUFA process have argued that FDA perceptions are skewed in favor of approval. Representative Maurice Hinchey has been a stalwart critic of the administration of the fee-based drug approval process. See Maurice Hinchey, Hinchey Introduces Sweeping FDA Reform Measure, May 10, 2007, http://www.house.gov/apps/list/press/ ny22_hinchey/morenews/051007FDAIntro.html (last visited Apr. 10, 2008) (arguing that the FDA is not fully accountable to U.S. taxpayers because it must collect fees from drug companies in order to fully function).
PROBLEMS WITH DIVERTING CASES

The recent suggestion by a drug industry defense counsel that the FDA should initially assess failure-to-warn tort claims\(^\text{72}\) is an unrealistic diversion for three reasons. First, more facts will always be available at the time of injury than on the time of approval.

Second, because of its limited resources, the FDA could not prioritize tort-based inquiries. In the past, all FDA employees received their salaries from the federal government’s domestic discretionary budget.\(^\text{73}\) Today, in contrast, the PDUFA statutory scheme rewards the leaders of the drug review division for complying with a congressionally set timetable.\(^\text{74}\) Because PDUFA does not reward tort claim referrals, the FDA would not likely receive sufficient resources to support Professor Struve’s hypothetical legislation. Granted, such legislation could devote money from user fees to pay for FDA screening of litigated claims. But this would diminish the primary role intended for these funds by PDUFA.\(^\text{75}\)

Last, an FDA team separate from the approving division conducts post-marketing review of new drug experiences, in the conscious separation of functions.\(^\text{76}\) This team’s workload has already begun to grow. It is unclear whether adding tort referrals to the team’s responsibilities would lead to a full appraisal of risks, or simply to a restatement of the self-serving rationale that led to the initial approval.

CONCLUSION

Professor Struve’s article merits close attention from courts faced with a defensive claim of FDA primary jurisdiction. If Congress passes her hypothetical legislation, should the courts defer and await FDA evaluations? I think not, because the FDA is not likely to give a timely or unequivocal response to such referrals. The costs of further litigation delay and the high likelihood of an equivocal response make Professor Struve’s proposal less desirable than the current method of airing opposing views before a jury.

We must acknowledge that the drug approval process is a series of intense negotiations. The FDA is no Oz, and those who would with-

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\(^{74}\) See FDA, FY 1998 Performance Report to Congress, supra note 69.

\(^{75}\) Litigation screening is not included among the functions to be paid by the fees. See Federal Food, Drug, and Cosmetic Act § 735(7), 21 U.S.C. § 379g(7) (2000).

hold tort remedies from juries must justify their position in light of these realities. The better solution is to let the jury look behind the curtain.