Straight talk with…
Guido Rasi

In November 2011, Guido Rasi stepped into the role of executive director of the European Medicines Agency (EMA), becoming only the third person to fill that role since the inception of the continental drug advisory body, in 1995. A year into his tenure, Rasi, a clinical immunologist who previously led the Italian Medicines Agency, has already overseen the implementation of stronger conflict-of-interest policies, a new board to coordinate scientific standards across the agency and a push toward greater transparency, among other measures.

In the recent months, Rasi's attention has shifted toward establishing a new 'staggered approval' option for the London-based agency—an idea that drugs for certain indications can receive provisional approval provided the medicines meet certain benchmarks and their developers conduct post-marketing surveillance. He spoke with **Roxanne Khamsi** about how the EMA can achieve better safety guidance and improved transparency.

How will the way the EMA works with country-specific regulators evolve during your tenure?

Although we started as just a secretariat, now I think we are like a hub for any regulatory agency to use as support. Before we were just a repository [of data], which is different from being a proactive, reliable source where people first think about going for information.

You have discussed the idea of rethinking the clinical trial model. Can you clarify what this would mean?

We all know that the clinical trial model has been developed under the so-called 'blockbuster model'. Now we know that blockbusters are over. At least there is nothing coming on the horizon. Therefore, we need to see what could be the next design for clinical trials and to address the need for more specific indications, smaller subpopulations and more targeted drugs. So maybe the big numbers and statistics will not be the leading tool of the future to assess the efficacy of a drug. The clinical trial [concept] should be rethought.

How do you envision staggered approval as working practically?

Basically, with the available data in limited populations I expect that we can accept some level of risk where the benefit of a drug outweighs the risk of the disease. Then, with very solid post-marketing data collection, we can remove any restriction, enlarge the indication and be reassured about the efficacy and safety of a drug. We now have the new pharmacovigilance legislation, which was passed by the European Parliament and Council in December 2010 and came into operation in July 2012. By law, a risk plan must be in place for the post-marketing of drugs, which allows us to gain real-world data to monitor drugs that went to the market quickly. The concept is clear. We now need to learn by applying it to real cases. I think the pilot [program] will formally start in 2013, but we need to identify some candidate drugs.

Will the EMA be suggesting a special sort of 'black box' labeling for drugs that are marketed under staggered approval?

I don't think we're that far into the details.

Ahead of such a big move, how do you plan to regain the public's trust following events such as the Mediator scandal?

Some scandals increase distrust, and that's why we have to rebuild the trust and say, 'OK, you want to see the data that I see to make my decision? Here are the data.' Why not? There is something more we are doing: we are starting to publish the agenda of the scientific committees and the minutes of their meetings. We have started with the Pharmacovigilance Risk Assessment Committee, the Paediatric Committee and the Committee for Orphan Medicines. All others will follow until the end of 2013, when we will publish all agendas.

What else are you going to do to make data more transparent?

We are going to publish them when the process of the authorization is over, making sure we respect data protection of the patient and any other commercial confidential information, in the interest of the company. [But] the data of clinical trials *per se* are not commercially confidential; we've already decided we are going to publish that. On November 22, we had a meeting with all the stakeholders to have a final clarification of what will be the best way to make this data publically available. And I trust in the long term this will be in the benefit of industry and of drug development.

The US has witnessed drug shortages, for example with the medicine Fabrazyme. What can the EMA do to prevent such drug shortages?

Most of the shortage [in that situation] came from manufacturing problems. What we are fostering—and interacting with the FDA [US Food and Drug Administration] on—is to try to build a worldwide capacity for the inspection [of drug producing facilities], and this will reinforce the possibility to avoid a shortage resulting from a manufacturing problem. It's a matter of [regulators] aligning our diaries. The same manufacturing plant might be inspected by us, the FDA and Japan. Why don't we put our agenda and diaries together and say, 'You go to inspect plant A, I'll go to plant B and you inspect plant C.' That way we triple our capacity. I prefer to rely on the inspection of another authority rather than have no inspection.

Do you think we might see this coordination by the end of next year?

I don't know. I cannot put a date on it, but I've started to become optimistic about it because the need is felt by everyone now.