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Material reviewed: FDA draft guidance: Patient-Focused Drug Development: Methods to Identify What Is Important to Patients (issued OCT 2019)

Advice:
The FPM has the following suggestions and/or comments to this guidance:

General:

1. the guidance seems to have substantial overlap with the guidance on patient-reported outcomes (Patient-Reported Outcome Measures: Use in Medical Product Development to Support Labeling Claims; AUG 12, 2009). To reduce extent of this guidance and ensure consistency, perhaps some references to the 2009 document may be helpful.

2. An area that could be added is the impact and assessment of coping mechanisms (i.e. the adaptations patients and their caregivers make to accommodate some of the issues, e.g. using a wheelchair to get out and about rather than struggling to continue walking).

3. Another area that could be added is caregiver burden. The anxiety (and perhaps embarrassment) about the impact their disease has on their family, friends and other caregivers is an additional burden for patients over and above the burdens caused by the disease process per se and it's frequently overlooked. For some patient populations (eg autism) the caregiver may be the only person that can communicate with a researcher, so some comments in the guideline about caregiver experience in this circumstance may be relevant.

4. Text and examples in section IV do not clearly enable / appear to allow Discrete Choice Experiment (DCE) methodology as a preference research method, where the analysis of the patient input is substantially more complex than a question-by-question / item-by-item analysis of responses (e.g. Heisen et al, Current Medical Research & Opinion 2016; 32:4: 787-796). Consider adding DCE-type experiments as an example of a possible quantitative analysis. Often the precise design of the DCE survey is determined by qualitative results from prior focus groups – consider mentioning DCE methodology in the mixed-methods section (V) too.

Specific comments on sentences:

19-44	Obtaining input from patients/caregivers on important clinical study design elements (e.g. acceptability of placebo) is increasingly relevant and the current wording makes it unclear if such type of input is covered in the current and other guidelines in this series. Consider making this explicit in the scoping of the document.
39-44	We agree and feel that the ability to make strong evidence-based judgments based on these data requires validation of scales, which may be helpful to add here.
90-92	It is very important to explore a diverse range of experiences, such that the severity of a disease at different stages may provide different challenges based on intensity, time or progression. This may impact the target population and their likelihood to see a benefit. In

	the same way as we consider personalisation based on biological targets and responses, we can overlay impact and likelihood of being able to benefit meaningfully here, as this may be important in population selection as well as in payer / reimbursement discussions.
165-167	We agree that this is an important reflection to not generate selection bias based on ability to participate or level of impairment related to the disease in question.
471	Use of social media is an interesting but still speculative area given the likelihood for responder bias, the impact of anonymity, absence of data on the respondent's background etc.
829-838	All important and valid points that we can support. It does not mention however that the mere fact of being in a study does not really reflect real life and study assessments for the trial may minimise the potential benefits of any intervention in comparison to placebo / comparator. If all patients have to undergo all assessments to maintain the blinding, then some benefits may be lost. Hence the observational or real-world evidence aspects are worth emphasising.