Faculty of Pharmaceutical Medicine survey of members on transparency in clinical trials

Analysis report

28 August 2014

Faculty of Pharmaceutical Medicine
of the Royal Colleges of Physicians of the United Kingdom

Advancing the science and practice of pharmaceutical medicine for the benefit of the public

Message from the President

This survey is the first time that we have requested information on the beliefs and practices of our members regarding the transparency of clinical trials. It is very gratifying to note that, as doctors practising pharmaceutical medicine, we see the world of publication of clinical trial results and access to data in a common light. Namely, we have a responsibility to the patient.

We cannot write evidence-based guidelines unless all trials are registered and the results published within a reasonable time frame of completion of the trial. We cannot satisfactorily answer questions unless we have access to results and data, whether positive or negative. There must be protection of the anonymity of people who participate in research. We cannot educate those who are unaware unless we are first prepared to reveal, in a timely manner, the results of all clinical trials. We must be sensitive to the commercial interests of sponsors. However, we should not be willing to sacrifice the needs of patients for unnecessary secrecy. The membership of the Faculty of Pharmaceutical Medicine clearly favours earlier publication linked to the completion of a clinical trial and not to market authorisation or discontinuation of the project.

The world has changed; society now demands greater transparency in clinical trials. The Francis report[1] from the public inquiry into practices in the Mid-Staffordshire NHS Foundation Trust has been published and its recommendations are being implemented. Sir Robert Francis QC wrote about the need to stand up and be counted within the NHS; those same principles apply to the world of pharmaceutical medicine and clinical trials. The pharmaceutical physician must represent the interests of patients and of society.

I hope that you will read this report and use the findings and recommendations within to benchmark your own practice.

Yours Sincerely,

Keith Bragman MD (Lond) FRCP FRCPath PFPM
President of the Faculty of Pharmaceutical Medicine

Introduction and overview of results

The issues around the release of data and the publication of results from clinical trials are currently undergoing debate.[2,3,4,5,6] In order to better understand the real impact that changes in the legal and ethical framework will have, the Faculty of Pharmaceutical Medicine (FPM) surveyed our membership on these issues.

The Faculty's members are at the heart of this debate. They work internationally as clinical pharmacologists, clinical research physicians, medical affairs physicians and regulators across a wide range of organisations: from multinational pharmaceutical and biotechnology companies and clinical research organisations (CROs) to regulatory agencies, academic centres and the NHS, and also as independent consultants.

From the 23rd of September to the 28th of October 2013, FPM members were invited to answer twenty four questions that analysed their experience and attitudes towards the transparency of clinical trials. We asked our members how they thought that the safe and responsible dissemination of clinical trial results and access to data could be best managed for the benefit of patients' health, and how the advantages and risks could be most effectively evaluated.

We requested that those taking the survey respond as pharmaceutical physicians with a duty and responsibility to patients, research subjects and society, and not on behalf of their employing organisations. We are very grateful to those who took the time to respond to the survey and give their opinions.

Of the FPM membership, 25% (379 persons) completed the survey in full. An additional 4% (61 persons) partially completed the survey. Thus, 29% (430 persons) participated in the survey. This is a high proportion of respondents and reflects the importance of the subject. The complete responses were used to calculate the numerator for answers to all questions. This ensured that the size of the population remained constant throughout. Data collected from the complete and partially complete responses (in parentheses) are shown, see Table 1. The addition of those individuals who partially responded did not alter the rate of response derived from the cohort of individuals who completed all questions.

For the purposes of this report 'results' is used to mean the summary results from a clinical trial, which include information on the primary and any secondary outcomes measured and statistical analyses. The term 'data' is used to mean the full clinical study report (or equivalent in a non-commercial setting), which contains the methods, analysis, results, individual patient data and conclusions of a clinical trial, with appropriate redactions to protect the anonymity of patients. It should be noted that the term 'patient' includes healthy volunteers in clinical studies.

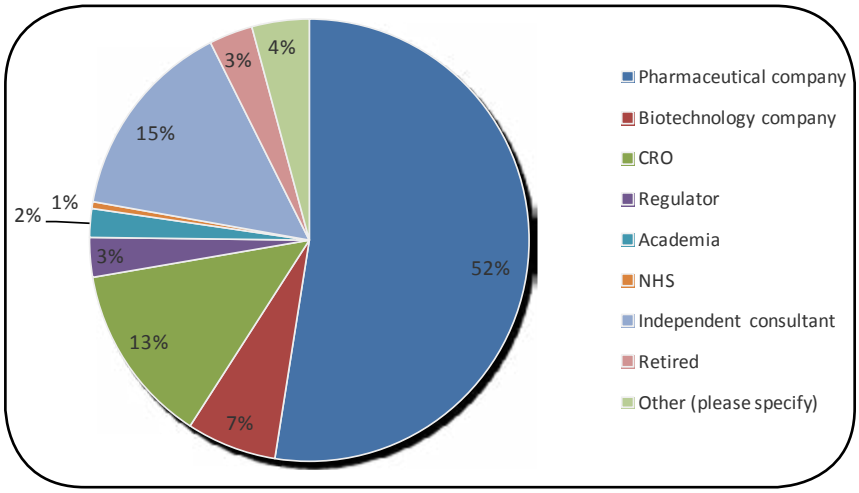

Figure 1: Responses to question "What kind of organisation is your primary employer?"

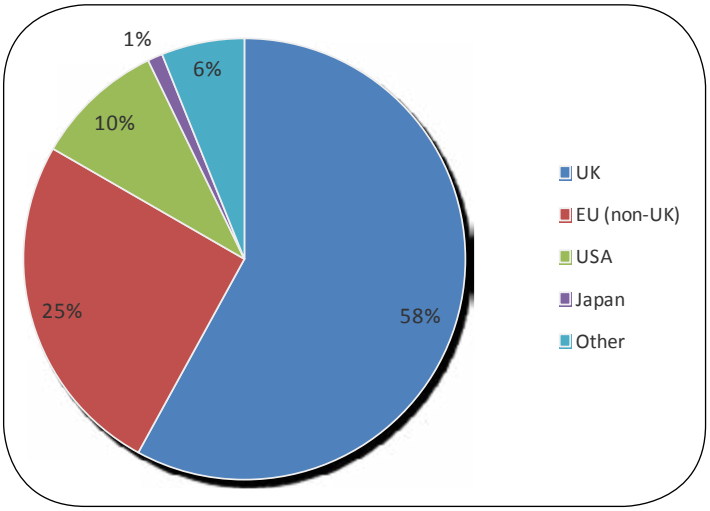

Figure 2: Responses to question "In which region do you predominantly work?"

Results and discussion

The demographic information from the survey is shown in figures 1 and 2, and summary results of the survey are in table 1, below, with the full results contained in the appendices. The results of the survey showed that pharmaceutical physicians, irrespective of their place of work or role, are dedicated to the health and well-being of patients. Eighty one percent of respondents agreed with the statement that "*there is a moral duty on all sponsors of clinical trials to make data available to the trial participants, general public and scientific community on completion of the study*", with 86% agreeing that "*Overall, an increased scrutiny of clinical trial data will enhance medical research, resulting in a stronger science base*". This is despite the fact that only 5% of respondents work for a government or not-for-profit organisation.

We were impressed by the high complete response rate (25% of the membership of the FPM) and by the overwhelming support for the principle of transparency of clinical trial data. The results show that doctors working in pharmaceutical medicine, the majority of them in the commercial sector, support the FPM's long-held position of access to data in the Guiding Principles (2006)[7] (updated version 2010)[8], our response to the Science and Technology Select Committee's report on clinical trials[6] and our signing the AllTrials petition (2013).[4]

The respondents are employed in a wide variety of working environments in pharmaceutical medicine, as shown in Figure 1. When comparing the results of those employed in academia or regulatory agencies, those who are independent practitioners and those employed in the commercial sector, it was found that there was very little difference in opinions between these groups. Hence, it was decided that the results, as discussed in this report, should not differentiate on this basis.

Approximately one third of the FPM's membership is based outside the United Kingdom (UK). The geographical spread in responses correlated closely to the spread of membership; for instance, 25% of the respondents are based in the European Union (EU) and 10% in the United States of America (USA) – see Figure 2. This indicates that these issues are just as resonant around the world as they currently are within the UK. The highest response rate (45%) was from Associate Members of the Faculty, who are undertaking Pharmaceutical Medicine Specialty Training and comprise 9% of the total membership of the FPM. It is encouraging that physicians in training are just as engaged, if not more so, in these issues than more established doctors.

The support amongst the FPM membership for the principles and practicalities of data sharing is encouraging, especially with the impending changes to the EU Clinical Trials Directive and the new European Medicines Agency (EMA) policy on clinical trial data. The results of the survey will continue to inform FPM policy on these issues. We have also used the results of the survey to propose new recommendations that can be used as the basis of a data-sharing policy. We would welcome your comments and/or questions on the survey itself or the results.

Table 1 – Key facts and figures

XX% – figure based on responses from those who completed the full survey
XX% – figure based all responses

Principles and ethics:

- 89% (88%) believe that increased publication of clinical trial results (including negative results) will ultimately lead to better medicines and better healthcare for patients
- 80% (79%) believe that increased transparency with access to clinical trial data will ultimately lead to better medicines and better healthcare for patients
- 87% (86%) believe that, overall, increased scrutiny of clinical trial data will result in a stronger science base and enhance medical research
- 10% (11%) believe that increased publication and dissemination of clinical trial results will harm the commercial environment in which companies operate
- 18% (18%) believe that increased access to clinical trial data will harm the commercial environment in which companies operate
- 81% (80%) believe that there is a moral duty on all sponsors of clinical trials to make data available to the trial participants, general public and scientific community on completion of the study

Registration of clinical trials:

- 95% (95%) believe that all clinical trials should be registered
- 44% (45%) believe that existing mechanisms and requirements such as those for ClinicalTrials.gov and the EU Clinical Trials Register provide adequate transparency regarding clinical trials being conducted and their results
- 75% (74%) believe that it should be a mandatory requirement to register all clinical trials
- 56% (54%) believe that all medicines in development should be allocated a unique, public identifier

Publication and dissemination:

- 57% (56%) believe that clinical trials (summary results and methodology) should be published within 1 year of completion, and 27% (28%) believe that publication should be linked to market authorisation.
- For efficacy data:
  - 38%, 53% and 40% (38%, 53%, 40%) (each being the most common response) believe that aggregated data should be made available for phases I, II+III, and IV, respectively
  - 53% (53%) believe that efficacy data should be made available after market authorisation
- For safety data:
  - 42% (42%) believe that anonymised clinical study reports should be made available for phase I clinical trials, and 46% (46%) and 38% (38%) believe that aggregated data should be made available for phases II+III and phase IV clinical trials, respectively
  - 60% (60%) believe that safety data should be made available before market authorisation

Table 1 continued

Managing access to data:

- 18% (18%) believe that all data should be placed on a central, publicly accessible database with no limitation to access
- 5% (5%) believe that companies should not be required to release clinical trial data into the public domain
- 36% (36%) believe that companies should be required to release data but may manage their own data release systems
- The majority of respondents who favoured a gatekeeper system agreed that a gatekeeper should fulfil all of the following requirements:
  - Obtain and verify the identity of any data requestor before providing access to data
  - Validate whether a requestor is 'appropriately qualified'
  - Require any data requestor to provide a project plan/protocol and plans for publication before providing access to data
  - Obtain confidentiality commitments prior to sharing data with the requestor, and
  - Notify the originator of the data as to who has requested and received their data
- 61% (61%) believe that either current regulatory organisations or a newly established independent body should act as the gatekeeper
- 27% (27%) believe that the sponsors of the trial should pay to fund a gatekeeper, 27% (27%) recommend that the regulator/public body responsible for access should pay, and 16% (16%) believe that the data requestors should pay a fee for access (very similar in partial responses)
- 34% (34%) believe that those requesting access should be healthcare professionals

Retrospective access to clinical trial data:

- 45% (43%) believe that historic data collected at least 5 years previously should be made available

Registration of clinical trials

The results of the Faculty survey showed overwhelming support (95%) for the requirement for all clinical trials involving human participants to be registered. The Faculty believes that the registration of a clinical trial is the first step in ensuring accountability and transparency in the development life cycle of a medicine, and can improve the chance that the results of the trial will contribute to the wider evidence base for healthcare decisions.

The survey results showed criticism of existing mechanisms and requirements for trial registration. There is a need to increase trial registration in facilities such as those for ClinicalTrials.gov,[9] the EU Clinical Trials Register[10] and the International Standard Randomised Controlled Trials Number (ISRCTN) Register.[11] One third of respondents thought that existing systems are inadequate. It was frequently remarked that current interfaces are not user-friendly and discourage detailed and timely updating. Registries do not currently capture all clinical trial types (voluntary for phase I and may not capture trials conducted in academia).

Most of the respondents who said that not all trials should be registered commented that very early phase exploratory clinical trials should not need to be registered, with "*unnecessary bureaucracy*" and "*commercial sensitivities*" being the most commonly given reasons. However, the Faculty believes that the positive benefits of registration – the reduction of the risk to the patient, publication bias, prevention of duplication of effort, and the promotion of collaborative working – is in patients' best interests. It seems reasonable to expect compliance with the World Health Organization (WHO) 20 item Trial Registration Data Set[12] of the minimum information that should be included when registering a trial.

Seventy five percent of respondents to the survey agreed that introducing regulatory or legal requirements for the registration of all trials would help to ensure compliance. While the need for commercial confidentiality is recognised, particularly for early phase studies, a simple form of registration should be in place and adopted to ensure accountability. The Health Research Agency (HRA) in the UK has already made it a requirement of research ethics committee (REC) approval that clinical trials are registered.[13]

The results of the question regarding an internationally recognisable and unique identifier for a clinical trial were more inconclusive. Only 56% of respondents favoured this approach, and substantial minorities were either opposed or unsure how this would work in practice.

- ***The FPM recommends that all clinical trials in humans must be registered before commencement of the trial, and that this should be a prerequisite of REC approval***

- ***The FPM recommends that clinical trial registries review their systems to ensure that registration of trials is as straightforward as possible. The systems should be adaptive and should include the capacity for all types and sponsors of trials to be registered***

Publication of summary results

Eighty nine percent of those responding to the survey said that increased publication of clinical trial results will ultimately lead to better medicines and better healthcare for patients. This positive message reinforces statements recently made by the House of Commons Science and Technology Select Committee (STC) in their report on Clinical Trials (Sept 2013):[6] "*We consider that summary-level results should be made publicly available for all clinical trials...*"; and the AllTrials campaign (Sept 2013):[14] "*A summary of results should be publicly available where the trial was registered, within one year of completion of the trial*".

The Faculty survey did not differentiate between positive and negative results. The Faculty believes that negative results are just as scientifically valid as positive results and should be in the public domain, in order to inform the wider research community and prevent duplication of trials. The historic reluctance of some journals to publish negative findings has been countered in recent times by a number of newly established, open-access journals such as *Pharmacology Research & Perspectives*, the *Journal of Negative Results in BioMedicine* and the *Journal of Pharmaceutical Negative Results*.

Only 10% of respondents thought that increased publication of trial results would have a negative commercial impact on the sponsor. The Faculty believes that although there is a perceived risk that the commercial competitiveness of companies will be affected by publication (especially of early phase clinical trials), the general advancement of knowledge will benefit both the health of patients and the robustness of companies. Publicly limited sponsors already have a fiduciary obligation to publish overall trial results that may meaningfully affect their equity price.

Fifty seven percent of respondents considered the publication of results within 1 year of trial completion to be appropriate. This is more than twice the proportion (27%) who considered that publication should be dependent on marketing authorisation being granted. Of the 16% of respondents who selected the 'other' option, the majority stated that publication within 2 years of completion of a trial was acceptable. In other words, 73% of respondents thought that clinical trials, irrespective of phase of development, should be published within 1–2 years of completion. It was commented that the actual date of publication is often outside the control of the author(s) and reliant on internal journal review processes. A guideline that submission of the results for publication should be within 1–2 years of trial completion would be more appropriate.

The Faculty has therefore adopted the position of recommending that summary results (whether positive or negative) of clinical trials must be published as soon as possible after trial completion. Publication of the summary results and methodology may require a time window of 1–2 years. However, we would question lack of publication activity, especially in a clinical trial which suggests that a medicine may alter or increase risk related to patient safety.

The survey suggests that publication should preferably occur within 1 year of completion and should not occur more than 2 years post-trial completion date. Market authorisation or discontinuation of the clinical programme may take several years or an indeterminate time, in which case the publication of the results of a clinical trial cannot be guaranteed and, in a worst-case scenario, they may never be published at all.

The '*Joint Position on the Publication of Clinical Trial Results in the Scientific Literature (2010)*'[15], issued by the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA), the European Federation of Pharmaceutical Industries and Associations (EFPIA), the Japanese Pharmaceutical Manufacturers Association (JPMA) and the Pharmaceutical Research and Manufacturers of America (PhRMA) (adopted by the IFPMA Code of Practice and subsequently the Association of the British Pharmaceutical Industry (ABPI)), states that:

"All industry-sponsored clinical trials should be considered for publication in the scientific literature irrespective of whether the results of the sponsors' medicine(s) are positive or negative. At a minimum, results from all phase 3 clinical trials and any clinical trial results of significant medical importance should be submitted for publication.

The results of completed clinical trials ... should be submitted for publication wherever possible within 12 months and no later than 18 months of ... the regulatory approval of the new medicine; or the decision to discontinue development."

Our survey results showed that a majority of those practising pharmaceutical medicine do not agree with these current industry guidelines. The inclusion of the term "*significant medical importance*" allows the sponsor too much leeway in deciding if and when to publish results.

- ***The Faculty recommends that summary-level results of clinical trials are submitted for publication soon after trial completion (ideally this will occur within 1 year of trial completion but it may take longer for reasons that are beyond the control of the sponsor)***

- ***The Faculty recommends that appropriate academic journals, with either traditional payment models or open access, continue to encourage and facilitate the publication of both positive and negative clinical trial results***

- ***The Faculty recommends that the pharmaceutical industry revisits its policy of publication time dependent on market authorisation and/or project discontinuation, and adopts the more generally accepted policy of publication based on trial completion date***

Access to clinical trial data

The survey results regarding the release of the data-sets obtained from a clinical trial mirrored those related to publication of results, with 80% agreeing with the statement that "*An increased transparency with access to clinical trial data will ultimately lead to better medicines and better healthcare for patients*." However, many respondents expressed caution regarding the appropriate and safe frameworks for the release of data.

Only 18% of respondents agreed with the statement that "*Increased access to clinical trial data will harm the commercial environment in which companies operate*" – a figure higher than that for publication of results (10%), but nevertheless low. It is understandable that employees of commercial institutions, especially those dealing with highly commercially sensitive data from early phase clinical trials, would be reticent to share all the data related to a clinical trial. However, only 5% of respondents agreed with the statement that companies should not be required to release clinical trial data. This seems to indicate that most of those expressing concerns regarding the commercial environment would be satisfied if they had assurances that appropriate measures were taken to protect the data from unscrupulous parties, including competitors from less well regulated countries where a 'land-grab' patent could be filed if 'free' access was to be allowed.

To ensure that adequate safeguards are in place to protect the anonymity and rights of patients, as well as retaining commercial incentives, almost all respondents agreed that some kind of 'gatekeeper' is required to manage the release of data. The majority of respondents who favoured a gatekeeper system agreed that a gatekeeper should fulfil all of the following requirements:

- Obtain and verify the identity of any data requestor before providing access to data
- Validate whether a requestor is 'appropriately qualified' (see below)
- Require any data requestor to provide a project plan/protocol and plans for publication before providing access to data
- Obtain confidentiality commitments prior to sharing data with the requestor, and
- Notify the originator of the data as to who has requested and received their data

Sixty one percent of respondents supported either the use of current regulatory organisations or the establishment of a new independent body to assume the gatekeeper function. Only 13% of respondents thought that the trial sponsor should manage the release of data. Therefore, whilst the Faculty commends the recent moves by some pharmaceutical companies,[16,17] to establish their own access portals, the Faculty would still recommend that this is carried out by an independent body. This will help to promote transparency and assuage the sometimes negative attitudes held by prescribers and users of the medicines produced by the pharmaceutical industry.

There was a split opinion between respondents on the funding models for a gatekeeper, with 27% saying that the sponsors of the trial should pay, 27% recommending that the regulator/public body should be responsible for access pay, and a significant minority, 16%, suggesting that the data requestors should pay a fee for access.

The question of who is 'appropriately qualified' to access data prompted a wide range of responses, from which it was difficult to draw any meaningful conclusions. Thirty four percent of respondents said that those requesting access should be healthcare professionals (HCPs), but did not necessarily restrict this to medically qualified HCPs. Thirteen percent suggested that scientists/ academics should be allowed access. Perhaps the most interesting statistic is that only 12% said that there should be no qualification requirement to request access to data. It can therefore be reasonably inferred that data access policies, whether they are the policies of individual companies or an independent body, should operate with some stipulations as to who is granted access to the data.

The level of access to data is an issue that attracts considerable debate – mainly regarding where to draw the line between accessing usefully detailed information and how patient confidentiality can be maintained. However, our survey delved deeper than simply the level of detail that could be accessed, and explored how a data access policy might distinguish between levels of access between different phases of trials, and also compared efficacy data with safety data (see appendices for full details).

Overall, the data from our survey indicate that most of those practising pharmaceutical medicine (35–50% of respondents, depending on the phase of the trial) would recommend the release of data in an aggregated form (i.e. from a single study arm or sub-group). This is opposed to allowing the full clinical study report (CSR) from a clinical trial or the equivalent in non-commercial settings to be accessible to third parties. This would be subject to anonymisation and redaction of individual patient data. A substantial minority did support the release of full CSRs, and this is more in line with current policy[18] on this issue. Our survey did not address whether data should be made available in a read-only format but, since the survey closed, the EMA has reversed its data release policy[19] from on-screen access only to allow researchers to download, save and print CSRs for academic and non-commercial research purposes.

Perhaps the most striking fact to emerge is that respondents were more inclined to advocate the release of full CSRs over aggregate data for phase I studies (especially for safety data) than phase II and phase III studies. This may reflect the fact that interpretation of small phase I studies is often highly dependent on evaluation of individual data and not summarised data. The respondents were more inclined to support the release of data for safety (37% of respondents across the phases) than for efficacy (28% of respondents). Across almost all phases and types of data, a minority of respondents (16–29%) thought that data should be released only when aggregated from multiple clinical trials. With regard to the question of when data should be released, a majority (53%) of those surveyed thought that efficacy data should be released after market authorisation had been granted. However, for safety data, this was reversed and a majority (62%) supported pre-market authorisation release of data, suggesting that the respondents placed greater importance on access to safety data than to efficacy data.

- ***The Faculty recommends that an existing regulator or a newly created body should be assigned the 'gatekeeper' function to ensure centralised, independent release of clinical trial data. The gatekeeper would be responsible for gathering the information referenced above***

- ***The Faculty recommends that the question of who is 'appropriately qualified' to access data be more closely analysed in order to allow suitable access to researchers, scientists and healthcare professionals posing legitimate scientific questions***

- ***The Faculty recommends that, at a minimum, the data from a trial sub-group should be released, and preferably the full clinical study report, or equivalent, with appropriate anonymisation and redaction***

- ***The Faculty recommends that safety data from clinical trials are made available as soon as possible after the completion of a trial, and release should not be dependent on market authorisation or discontinuation of the programme***

Retrospective access to trial data

This was one of the most divisive and complicated topics in the survey. Almost 25% of respondents stated that there should be no requirement for the release of historic data from clinical trials, citing the logistical challenges of accessing data from different, old databases, and following site moves and mergers etc. However, a majority (69%) did support some requirement for retrospective release, with the most commonly agreed time frame being that data from ~5 years ago should be made available, upon request, for scrutiny. Many respondents thought that there should be no time limit for making data available.

- ***The Faculty recommends that historic data collected at least up to 5 years previously should be made available***

Conclusions

The results of the Faculty of Pharmaceutical Medicine survey of members on transparency in clinical trials have shown that pharmaceutical physicians, around the world, overwhelmingly support the principles of increased access to the results and data from clinical trials. There is obvious agreement that patients will ultimately only benefit from this spread of knowledge and will be able to access more effective and safer medicines.

From the registration of trials to the accessibility of historic and current clinical trial data, the survey results indicate that the views of pharmaceutical physicians are sometimes not aligned with those of the sponsor and current requirements. However, a minority of respondents suggested that the commercial environment in which pharmaceutical companies operate would be adversely affected by increased scrutiny of the data from clinical trials.

The only questions for which there were no clear-cut answers were those related to the funding models for a gatekeeper to manage access to data, and who is qualified to be granted access. Depending on developments in regulatory policy, the Faculty may revisit these questions in the future. This would be to provide further guidance to stakeholders on these issues.

The Faculty will continue to advocate changes in policy and practice in clinical trial reporting. We will work with all stakeholders to continue to advance the science and practice of pharmaceutical medicine for the benefit of patients and society.

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About the Faculty

The Faculty of Pharmaceutical Medicine is a professional membership organisation and standard-setting body, with more than 1,500 members, who are practising or retired pharmaceutical physicians or those with a professional interest in the specialty. Approximately one third of the membership is outside of the United Kingdom. The FPM sets the curriculum for the postgraduate training programme Pharmaceutical Medicine Specialty Training (PMST) and sets the syllabus for several exams in the specialty.

The Faculty is a registered charity and therefore ultimately exists for the benefit of patients and the public. Charity number 1130573.

Our mission is to advance the science and practice of pharmaceutical medicine by working to develop and maintain competence, ethics and integrity and the highest professional standards in the specialty for the benefit of the public. The Faculty seeks, through its activities, to bring about an improvement in the health of the public.

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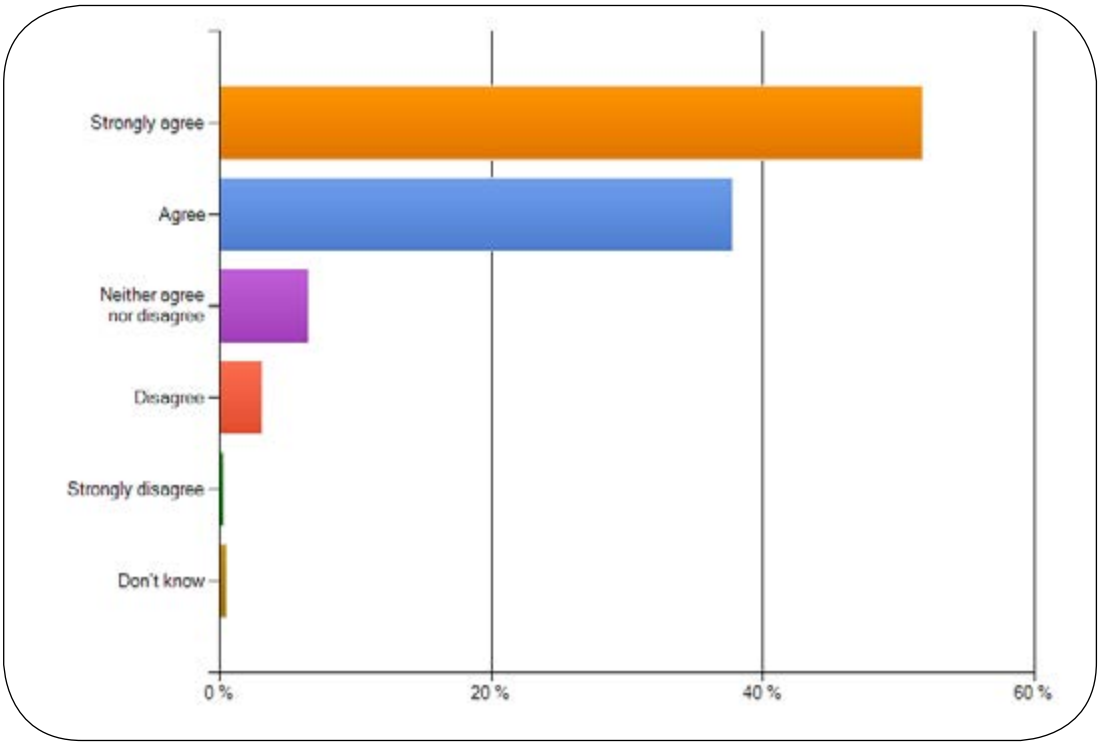
Appendix 1: Demographic data

- 379 completed the survey (430 started) – 25% of total membership (29% started)
- The highest response rate was among Associate (training) Members – 45%
- Number of responses:
    - Associate - 59 (15.6% of respondents)
      59/132 = 44.7% of Associate Members
    - Affiliate - 40 (10.6%)
      40/339 = 11.8% of Affiliates
    - Member - 111 (29.3%)
      111/423 = 26.2% of Members
    - Fellow - 168 (44.3%)
      168/630 = 26.7% of Fellows
    - Non-member - 1
- Geographical response broadly corresponded to the geographical spread of FPM members – 58% of the respondents are based primarily in the UK, 25% based elsewhere in the EU, 10% based in the USA and 8% based in the rest of the world (see Figure 1).
- Type of work (see Figure 2):
    - 59% of respondents work for a pharmaceutical or biotech company
    - 15% independent
    - 13% CRO
    - 3% regulator
    - 2% academia or NHS

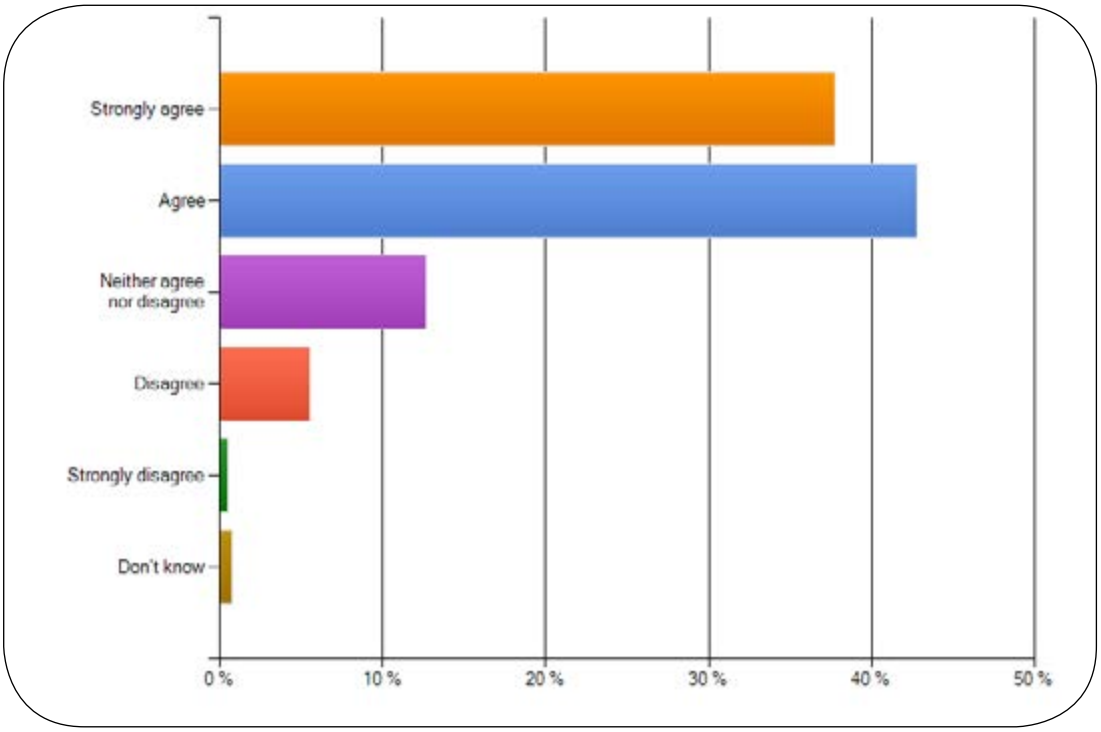
Appendix 2: Full results and data

Principles and Ethics of Clinical Trials and Results/Data Access

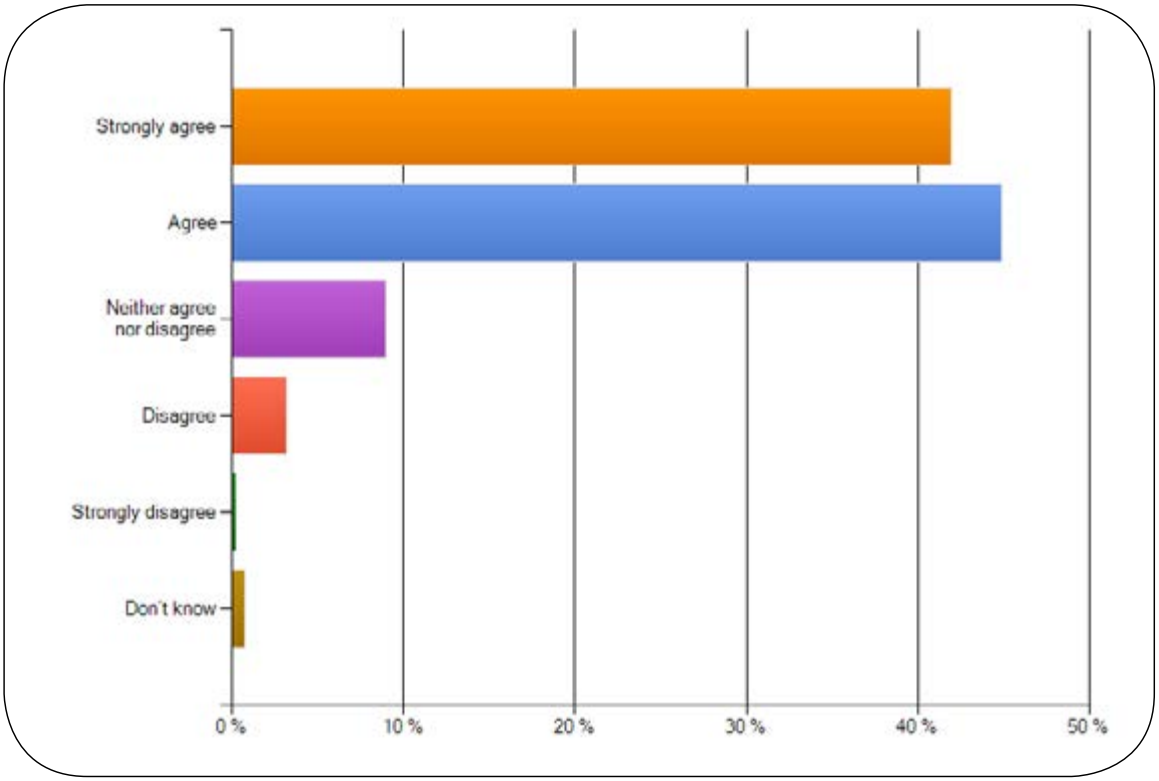
Q - Increased publication of clinical trial results (including negative results) will ultimately lead to better medicines and better healthcare for patients.



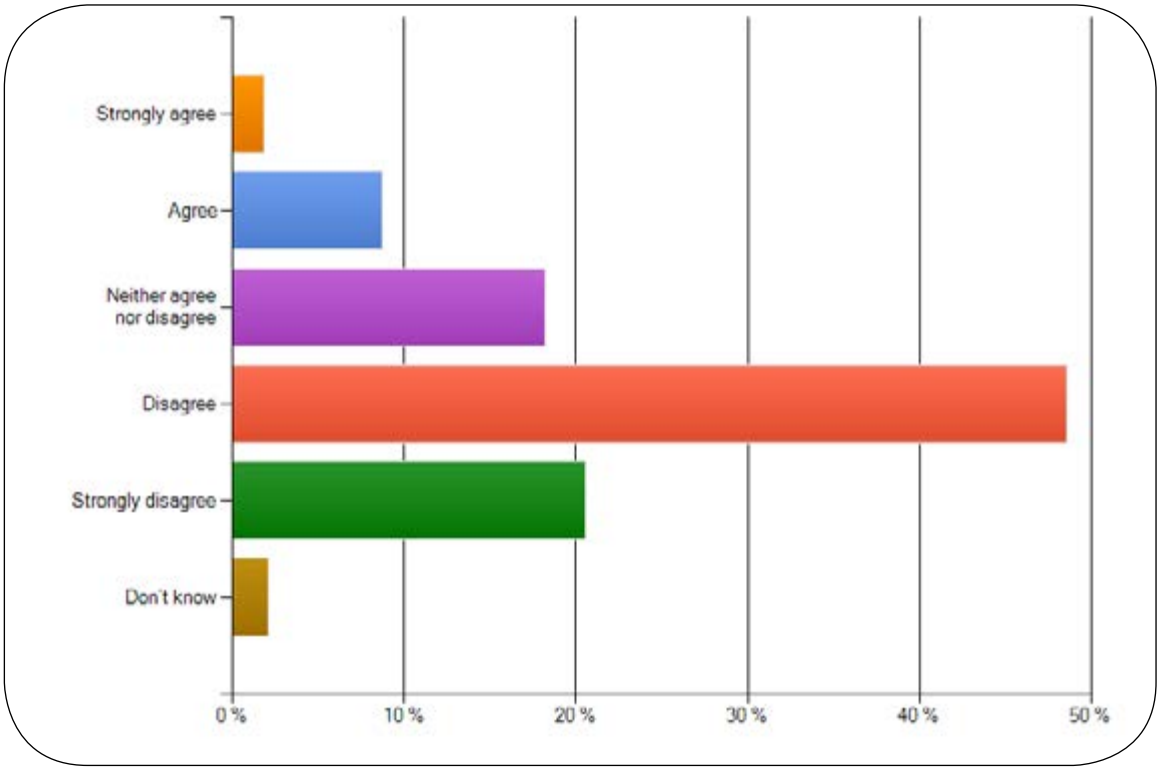
Q - Increased transparency with access to clinical trial data will ultimately lead to better medicines and better healthcare for patients.



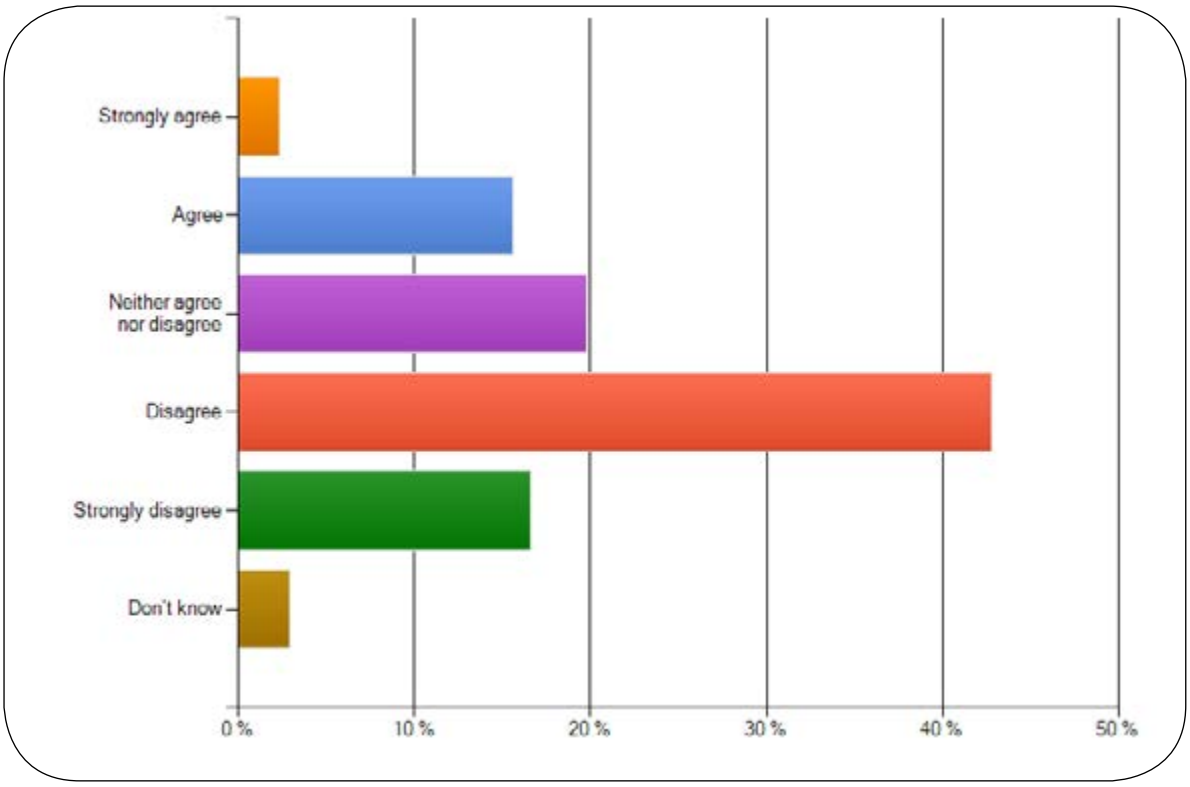
Q - Overall, an increased scrutiny of clinical trial data will enhance medical research, resulting in a stronger science base.



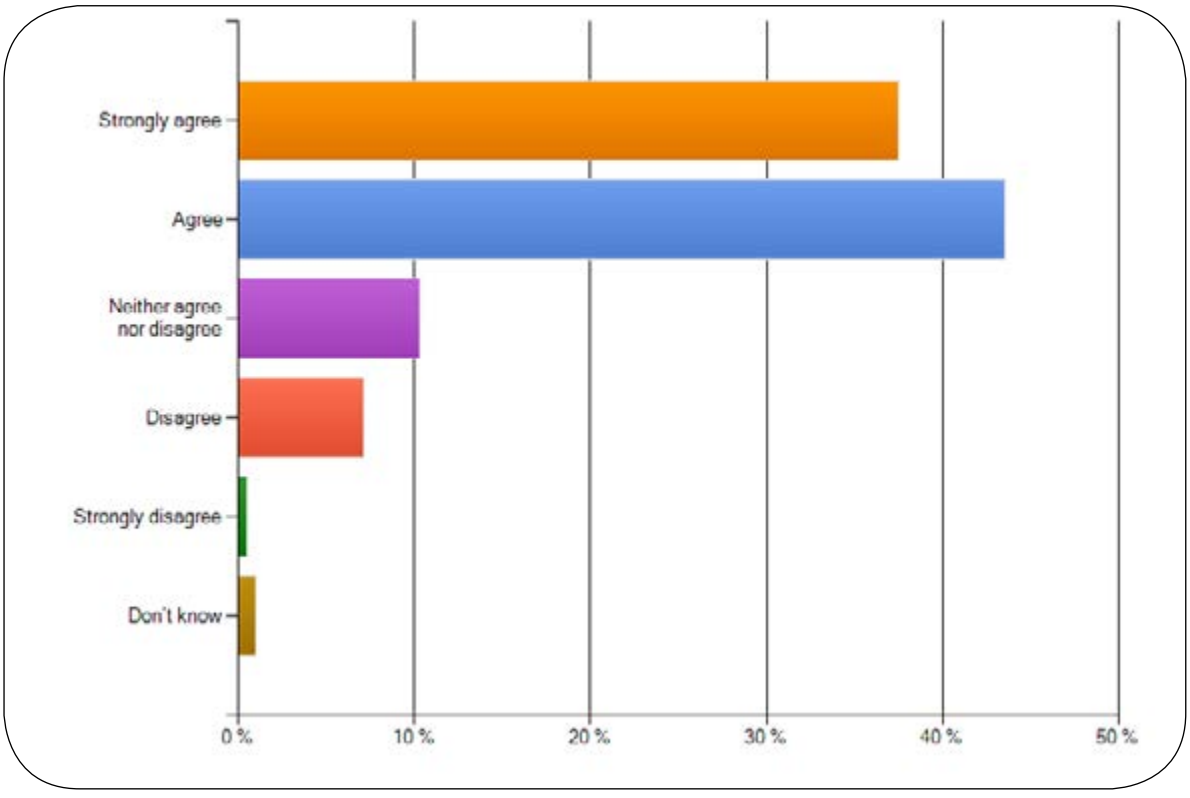
Q - Increased publication and dissemination of clinical trial results will harm the commercial environment in which companies operate.



Q - Increased access to clinical trial data will harm the commercial environment in which companies operate.



Q - There is a moral duty on all sponsors of clinical trials to make data available to the trial participants, general public and scientific community on completion of the study.

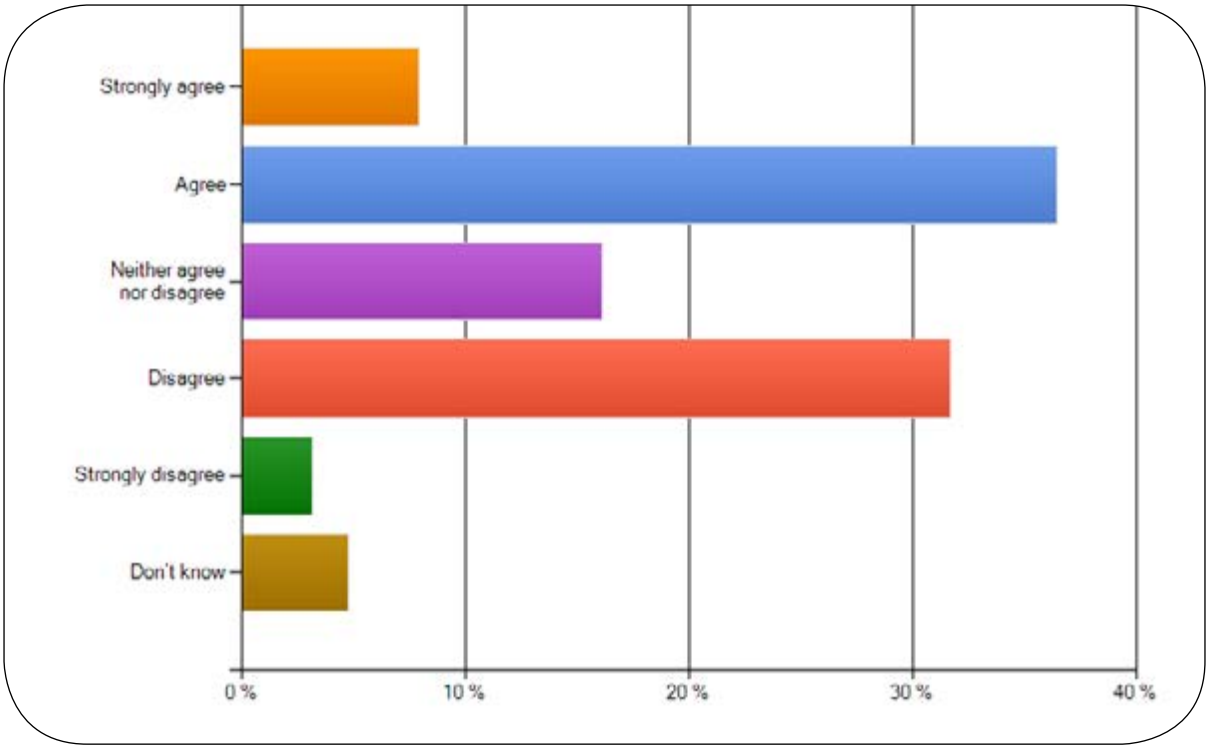


Registration of clinical trials

Q - All clinical trials should be registered.

- 95% of respondents said 'yes'

Q - Existing mechanisms and requirements such as those for ClinicalTrials.gov and the EU Clinical Trials Register provide adequate transparency regarding clinical trials being conducted and their results.



- Comments:

Response category	**n**
Database not updated in a timely manner, especially with results or amendments to study designs/protocols	33
Data in current registries are not detailed enough to allow use	14
Current data format is not user friendly	8
Current registries do not capture all trial types (voluntary for phase I and does not capture trials conducted in academia)	8
Does not capture data from all regions of the world (i.e. not worldwide, and caters mostly for countries in the ICH Tripartite regions)	3
Other non-specific responses (e.g. confirming why they agree with the statement or not answering the question)	5

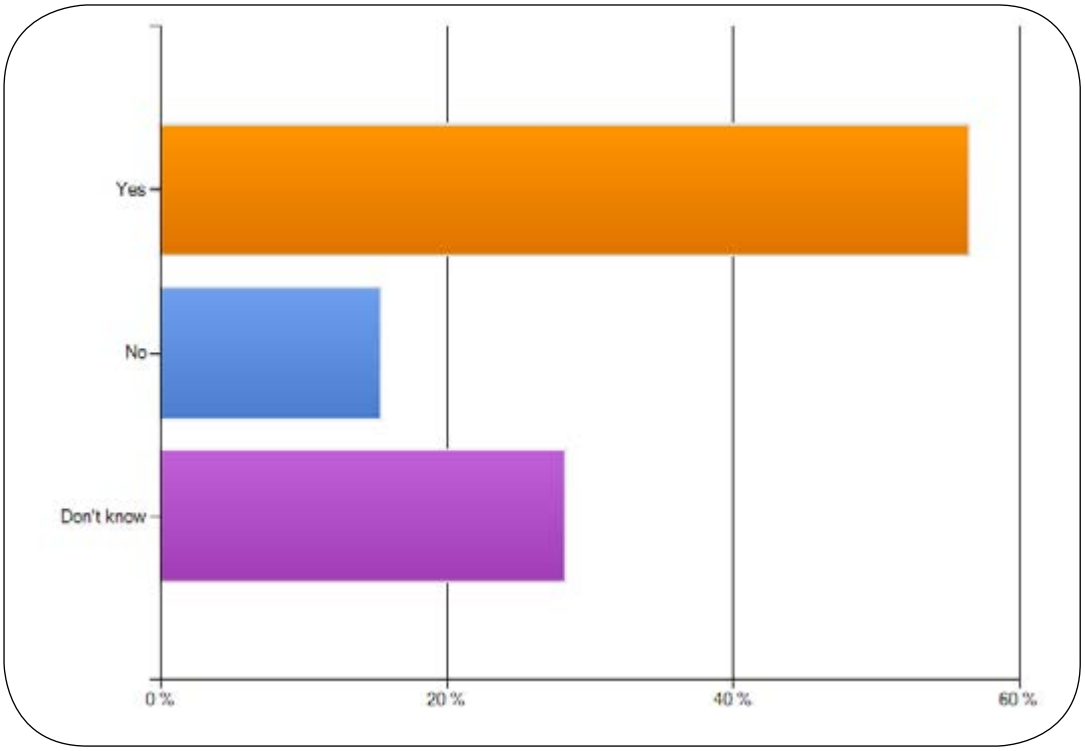
Q - How can we ensure that all trials are registered?

- Responses fell into the following categories:

Response category	**n**
Make it a mandatory regulatory requirement*	170
Make it a legal requirement	32
Make it a mandatory requirement for journal publication of data	19
Current systems/arrangements are adequate	18
By use of a "self-regulation" system	11
Not sure/not specified	11
Others**	9

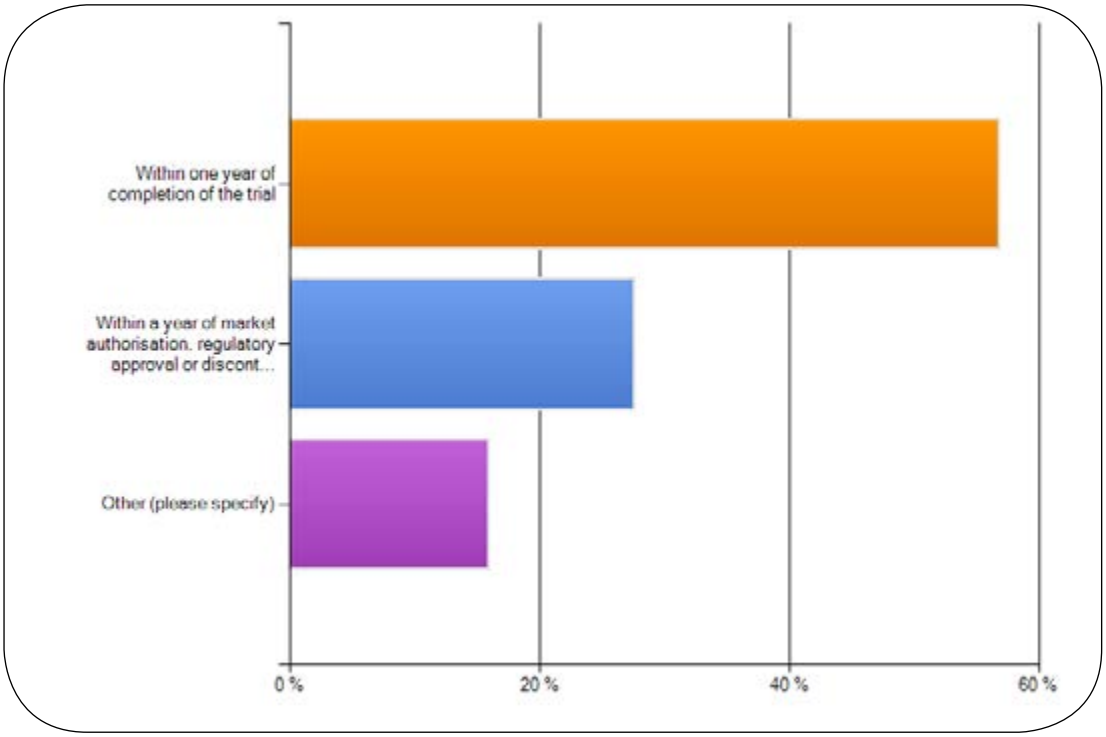
** This referred mostly to making it a pre-requisite to register all clinical trials before study approval during the Clinical Trials Application process, including getting ethical approval.*
*** Individual responses including making this a government mandate, local health authorities, audits by independent organisations, establishment of an independent central database (3 responses) etc.*

Q - Should all medicines in development be allocated a unique, public identifier?



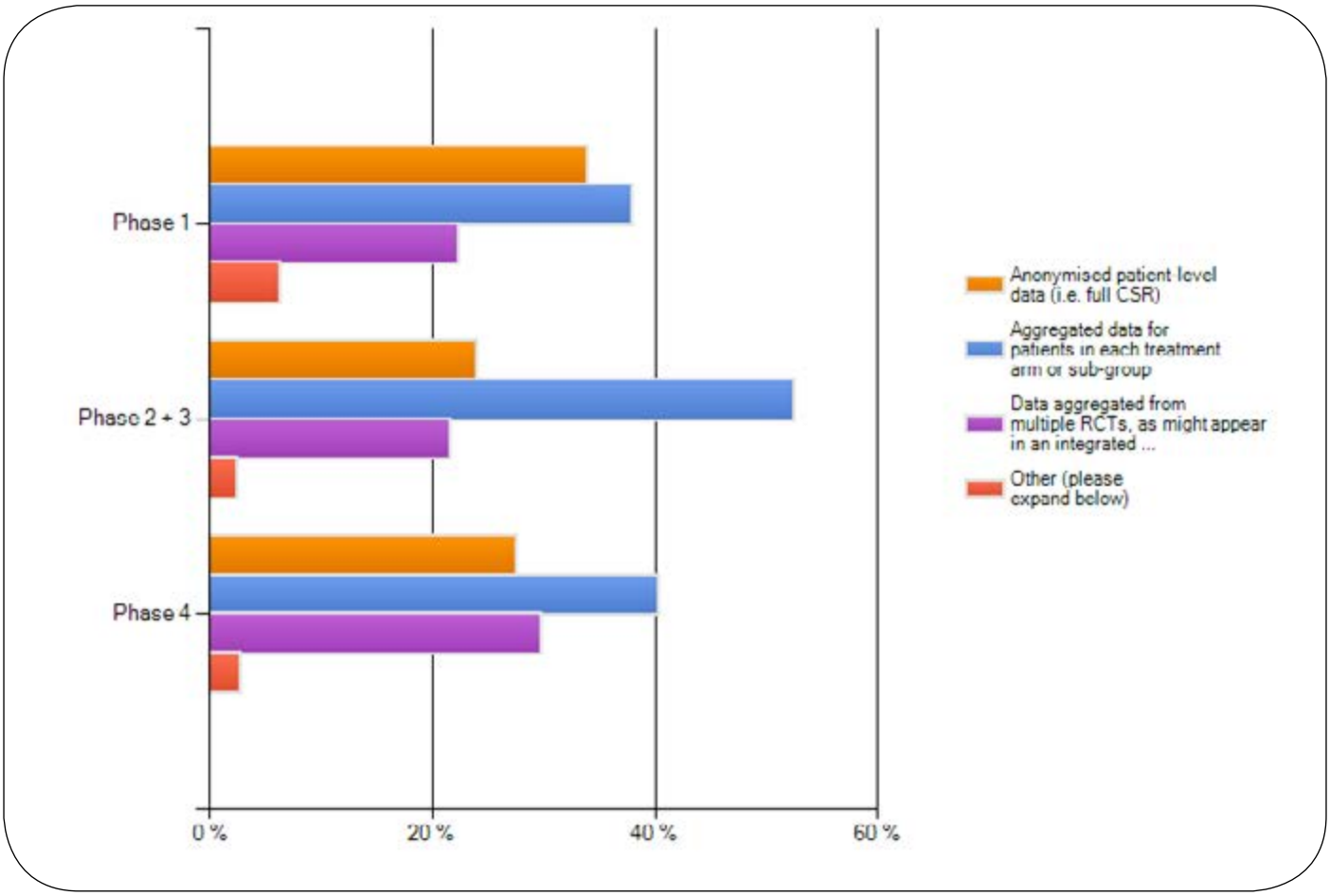
Publication and Dissemination of Study Results

Q - What is an appropriate time frame for the publication of the summary results and methodology of clinical trials?

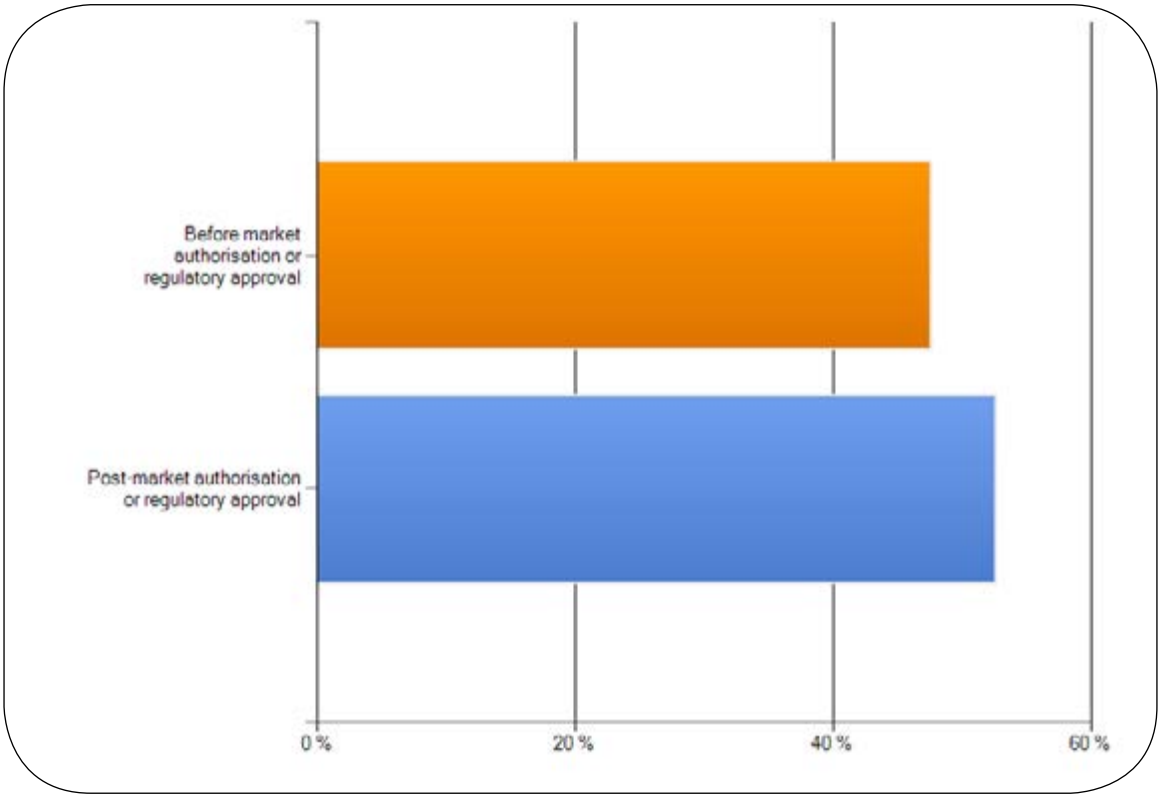


Access to clinical trial safety and efficacy data at different stages of clinical research and role of a gatekeeper

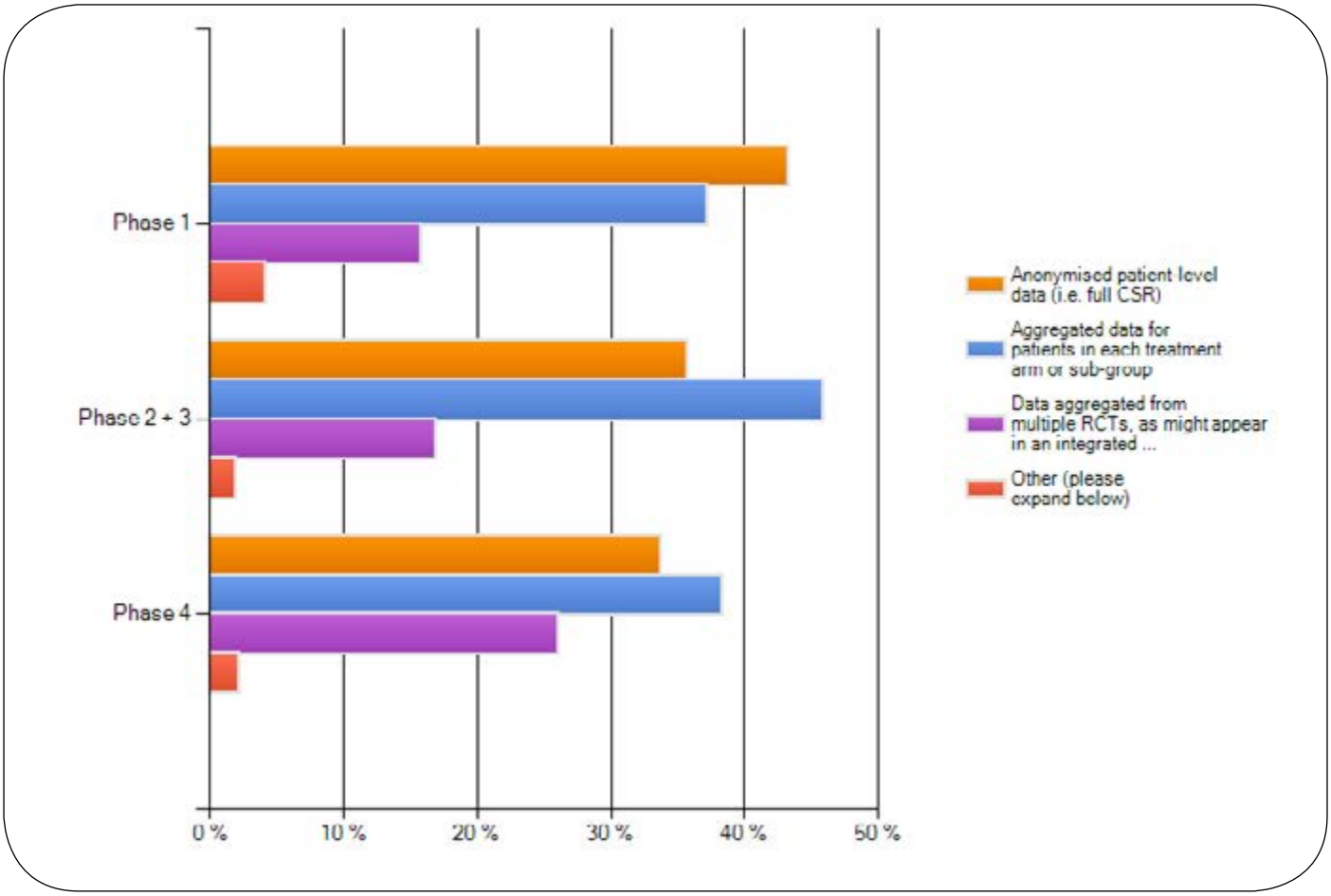
Q - For EFFICACY data – what is an appropriate level of data to be made available?



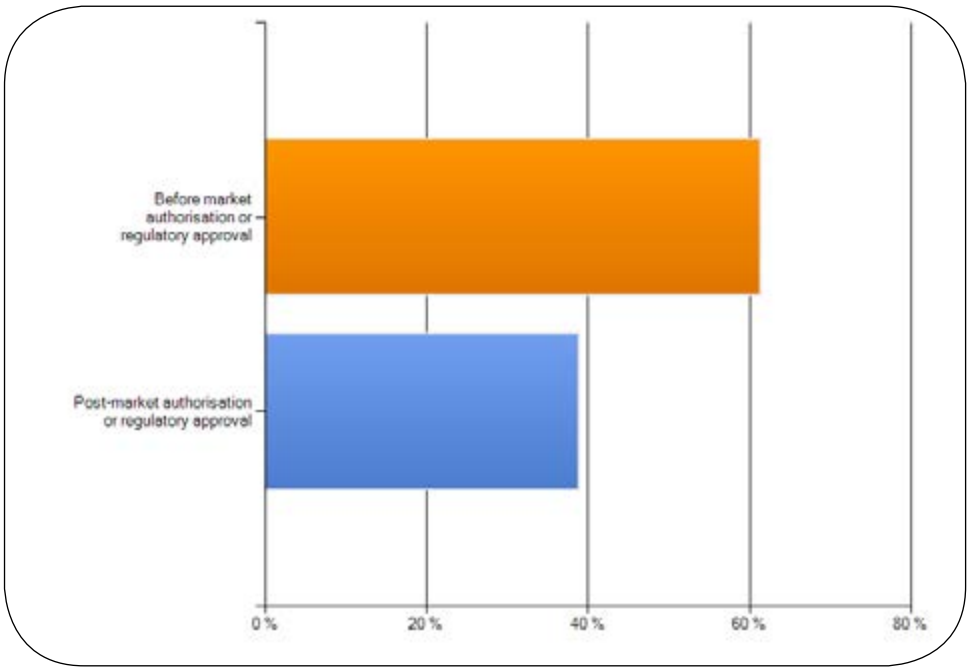
Q - For Phases 1, 2 and 3: When should access to efficacy data become available?



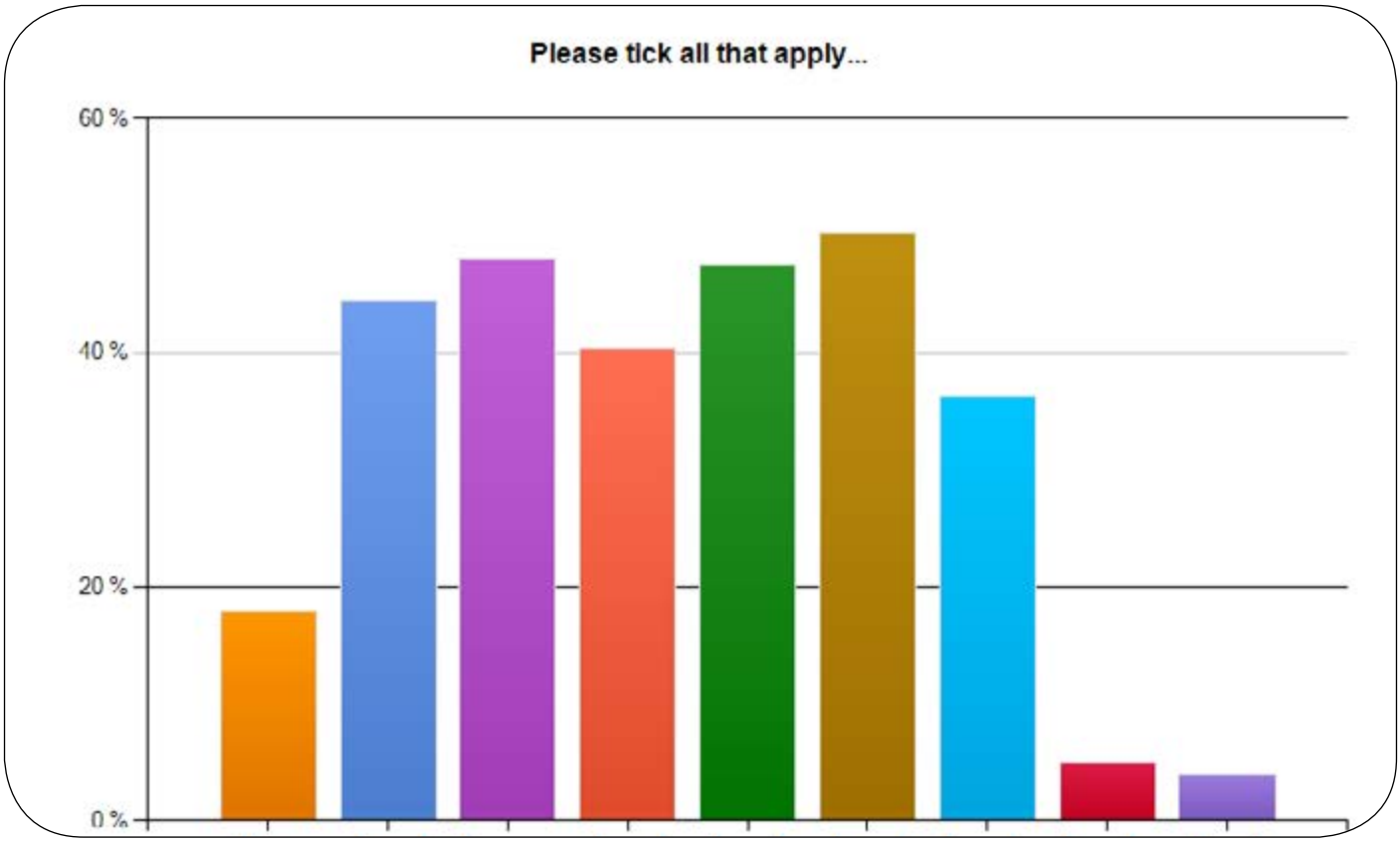
Q - For SAFETY data – what is an appropriate level of data to be made available?



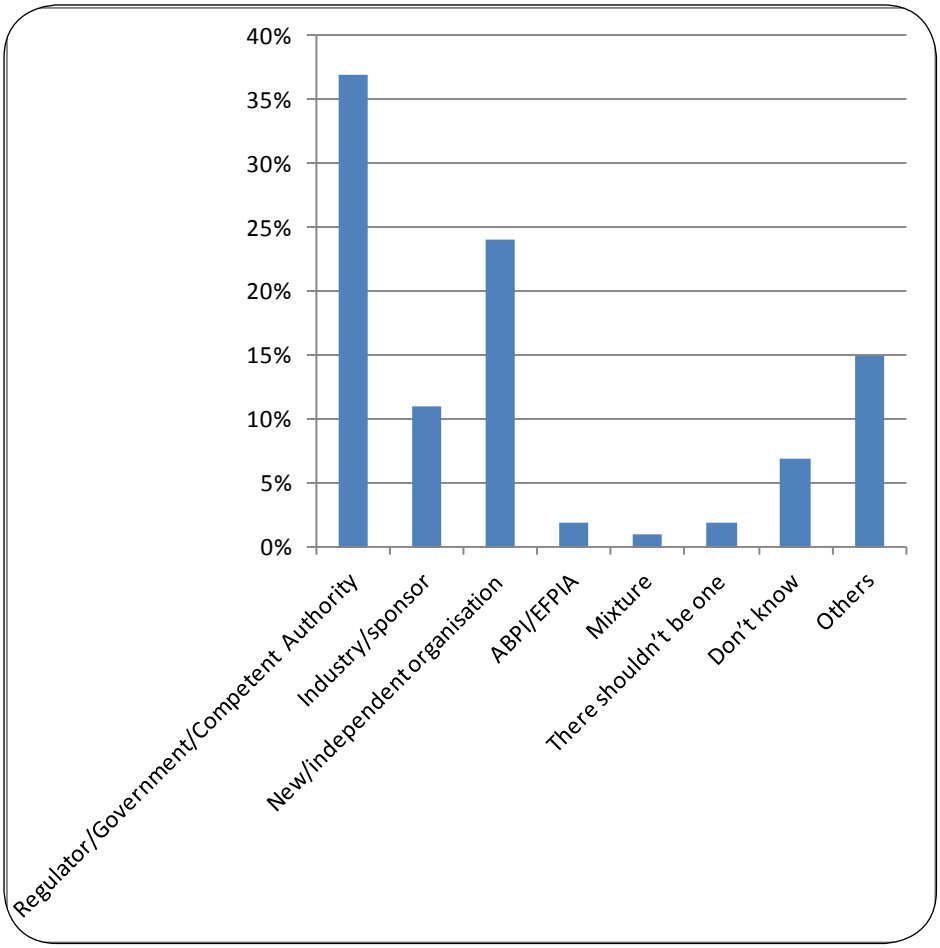
Q - For Phases 1, 2 and 3: When should access to safety data become available?



Q - How can we ensure patient confidentiality and safeguard commercially sensitive information, whilst ensuring appropriate access to clinical trial data? Should there be a gatekeeper and who should it be?



Q - Which organisation should act as a gatekeeper?



Q - If a centrally managed 'gatekeeper' is established then how should it be funded?

Response Category	**n**
Study Sponsors/Industry	68
Governments/Governmental Bodies/Public Funds	67
Joint Industry/Governments/Regulatory Authorities	41
Fee for Service (Data requesters pay a fee)	40
Regulatory Authorities	22
Independent Bodies	9
Not Specified/Unsure	26

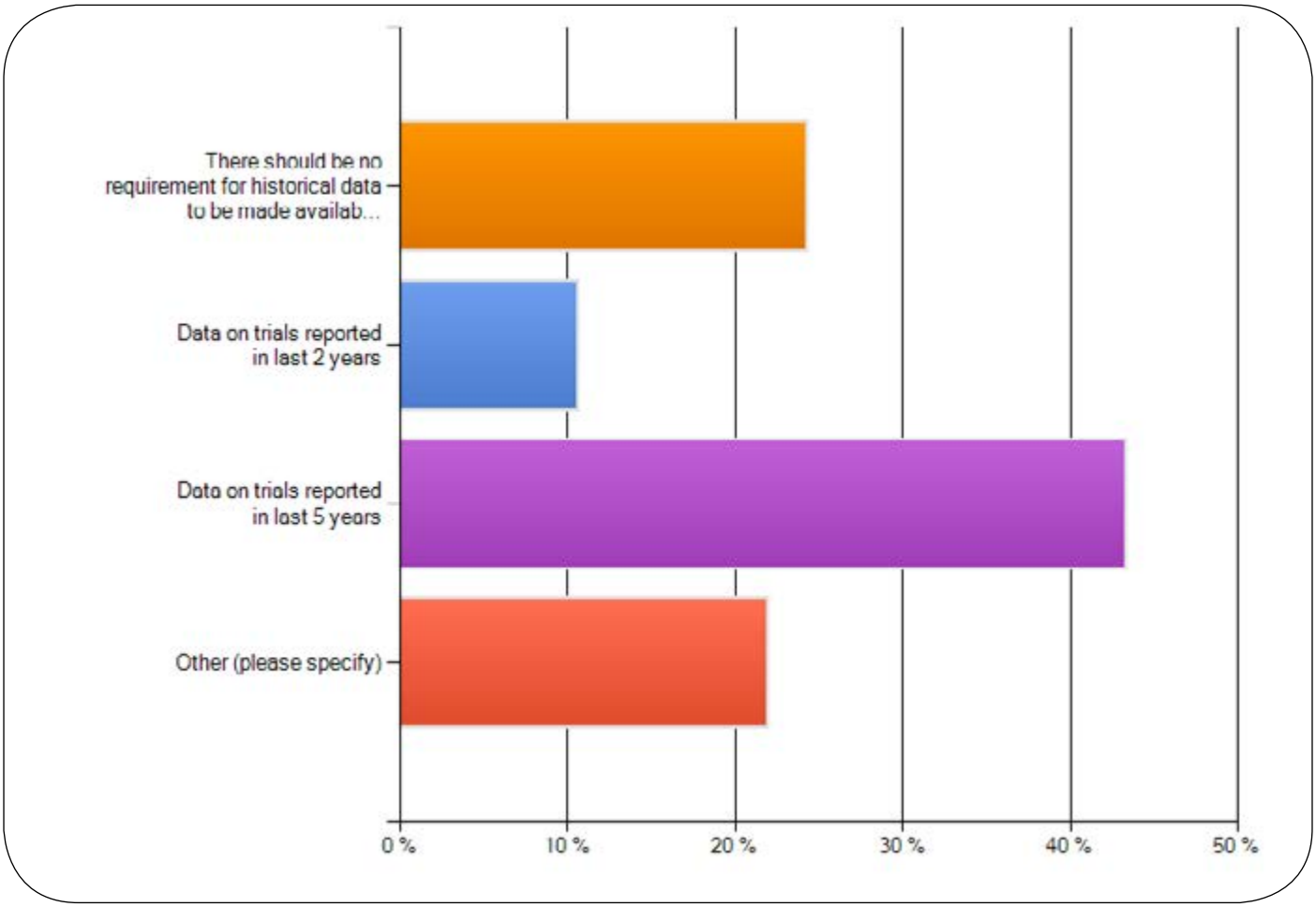
Q - Regarding the qualifications of the requestor – what constitutes 'appropriately qualified'?

Response Category	n
Healthcare Professionals*	81
Scientists/Scientific Background/Academics	36
Anyone with Interest**	29
Statisticians/Epidemiologists/Data Management Experience***	26
Institutions/Scientific/Academic Organisations	25
Not Specified/Not Sure	75

*Includes Physicians, Medically qualified, Specialists, Pharmacists, Research Physicians
**comments includes no restrictions to qualifications, those agreed by government to have access, for as long as request is appropriate, no conflict of interest, and members of the press as examples
***Includes category "qualified to analyse data" (n=8)

Retrospective release of data

Q - When should data from historic clinical trials be made available?



Response Category (not mutually exclusive)	**n**
There should be no time limit for making these data available	37
Up to 5 years*	7
Up to 10 years**	8
More than 10 years	8
Case by case evaluation	8
Not possible/will not work***	5
Do not know/Not specified	16

*Option available as a response to question. Not clear why this appeared in the open responses
**Example responses linked this to the establishment of EU directives, regulatory E-submissions, establishment of EudraCT
***Example responses include comments that this would be too arduous, will be difficult, if done will be significantly restrictive